A study to explore how interventions support the successful transition of Overseas Medical Graduates to the NHS: Developing and refining theory using realist approaches

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A study to explore how interventions support the successful transition of Overseas Medical Graduates to the NHS: Developing and refining theory using realist approaches

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Abstract

Background:

The UK's National Health Service (NHS) currently relies on overseas doctors to ensure effective healthcare delivery. However, concern has grown around their regulation and practice and there is a recognition of the need to support overseas qualified doctors to make a successful transition to the NHS. Interventions have been implemented to address transitional issues without sufficient exploration of what is likely to work or how much training and support are appropriate. The absence of a supportive framework, targeting social, cultural and work related issues, has led to overseas graduates feeling stressed, being isolated and experiencing mental health issues. Difficulties in career progression, retention and performance are also evident. This thesis explores and evaluates interventions that have been developed to support the transition of overseas medical graduates to the UK.

Method:

A realist approach was adopted. A realist synthesis (exploration of literature and development of initial theory) was conducted. A realist evaluation was then completed to test and refine theory. The main intervention subject was the Programme for Overseas Doctors (POD) developed within one North East Trust. A comparative case study design, using mixed methods, was used (including interviews, questionnaires, researcher observation and analysis of performance data).

Findings:

A synthesis of the findings, including 123 interviews, illustrated that three key contextual levels; organisational, training and individual, will likely impact on the adjustment of overseas doctors (including performance, retention, career progression and wellbeing). One of the main outcomes of this thesis is a transferable, theoretical explanation of how interventions can successfully support the transition of overseas medical graduates to the NHS.

Conclusions:

In order to successfully support the transition of overseas doctors, interventions need to be more comprehensive and broad ranging than a simple induction or one-off training programme. Interventions must focus on building an open and supportive culture, address individual needs, and include ongoing support from all staff beyond the initial intervention. This work has reviewed factors that contribute to a successful intervention and has put forward recommendations for future policy, interventions and future research.

Contents

List of figures

List of tables

List of boxes

List of terms

ADHB: Auckland District Health Board

AH: Amity Hospital

ARCP: Annual Review of Competence Progression

AMEE: Association for Medical Education in Europe

BH: Blossomvale Hospital

BMA: British Medical Association

CAPP: Clinician Assessment for Practise Program (CAPP)

CH: Clearwater Hospital

CHC: Cultural Health Capital

CMO: Context Mechanism Outcome

CMOc: Context Mechanism Outcome configuration

CPD: Continued Professional Development

ECFMG: Educational Commission for Foreign Medical Graduates

EEA: European Economic Area

EG: Educational Governance

EU: European Union

FY1: Foundation Year 1

FY2: Foundation Year 2

GMC: General Medical Council

GP: General Practice

HEE: Health Education England

HEEEM: Health Education England East Midlands

HEENE: Health Education England North East (formerly HENE: Health Education North East)

IELTS: International English Language Test System

IMG: International Medical Graduate

MTI: Medical Training Initiative

NACT: National Association for Clinical Tutors

NEPOD: North East Programme for Overseas Doctors

OMG: Overseas Medical Graduate

OSCE: Objective Structured Clinical Exam

PLAB: Professional and Linguistic Assessments Board

POD: Programme for Overseas Doctors

PPOS: Patient-Practitioner Orientation Scale

RAMESES: Realist And Meta-narrative Evidence Syntheses: Evolving Standards

RCGP: Royal College of General Practitioners

R&D: Research and Development

REACHE: Refugee and Asylum Seekers Centre for Healthcare Professionals Education

REPOD: Refugee Programme for Overseas Doctors

SAS: Staff and Specialty (grade doctor)

SUIs: Serious Untoward Incidents (SUIs)

USMLE: United States Medical Licensing Exam

WtUKP: Welcome to UK Practice

Glossary of key terms

Overseas Medical Graduate (OMG)	A physician who has graduated from a medical school outside of the host country in which they intend to practise. Both International (IMGs) and European Economic Area (EEA) graduates are included in this term (specific to UK). OMGs are the focus of the thesis.
International Medical Graduate (IMG)	A physician who has graduated from a medical school outside of the EEA (specific to UK).
European Economic Area (EEA) graduate	A physician who has graduated from a medical school outside of the UK but within the EEA.
Intervention	An intervention is a combination of programme elements or strategies designed to produce behaviour changes. They are inserted into existing social systems that are thought to underpin and account for present problems. Changes in patterns of behaviour, events or conditions are then generated by bringing fresh inputs to that system in the hope of disturbing and re-balancing it[1].
Acculturation	The psychosocial adjustment and adaption to a new culture for those from another culture[2].
Work adjustment	Comfort with the assigned job or tasks.[3] Work adjustment is indicated by the satisfaction of the individual with the work environment and their performance, and by the satisfaction of the work environment with the individual's performance.
Cultural adjustment	Process of adjustment to the host culture that enables the individual to work effectively and live comfortably. It is associated with various non-work factors such as general living conditions, local food, and transportation[3].
Interaction adjustment	Comfort associated with interaction with host country nationals both inside and outside work.[3]
General adjustment	Comfort associated with practical issues e.g. visas.
Realism	The basic idea of realism is that observational evidence alone cannot establish causal uniformities between variables.[4] It is necessary to explain why the relationships come about; looking at what connects its various inputs and outputs. Casual associations are strongly influenced by setting and context. Context + Mechanism = Outcome (CMO) formula is used as a guiding principle to realist enquiry.
Realist synthesis	Logic of inquiry that attempts to answer the question, `What works, for whom, in what circumstances…and why?'[5]. Secondary data is collected. The key goal of a realist synthesis is to uncover middle-range theories (definition below).

Realist evaluation	As above, but instead primary data is collected. Used within this piece of research to refine the middle-range theories and programme theory.
Grand theory	A grand theory is an overarching philosophy, or perspective, that is formulated at a high level of abstraction. It makes generalisations that apply across many different domains[6]. It supplies a 'language' that particular themes and descriptions can be constructed to explore theory that may remain under articulated.
Middle-range theory	Theory that explains how and why the context influences or limits the mechanism. They are semi-predictable patterns of functioning (CMOc) that can be tested within the realist enquiry. These theories are useful for understanding a problem or to guide specific interventions[6].
Programme theory	A 'small theory' that describes how the specific intervention is expected to lead to its outcomes and in which conditions it may do so (theory often developed prior to evaluation through pre-existing theory and discussion with stakeholders). It specifies what mechanisms will generate the outcomes and what features of the context will affect whether or not those mechanisms operate.
Context (C)	The conditions that may influence the mechanisms to produce a particular pattern of outcomes.
Mechanism (M)	The process of how participants interpret and act upon the resources offered by the intervention and their reasoning in response. They are defined as "…underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest"[7].
Outcome (O)	The effects produced by the causal mechanisms being triggered in a given context.

Statement of Copyright

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Dissemination

Publications:

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Kehoe, A. Rapid response to "NHS equality policies focus too narrowly on ethnicity" by Hiranthi Jayaweera & Helen McCarthy - More than just a programme. *BMJ Careers,* January 2016.

Impact:

The realist synthesis paper was the focus of the journals commentary:
Dahm, M. R. and Cartmill, J. A. (2016). Talking their way to success: communicative competence for international medical graduates in transition. *Medical Education*, 50: 992–993.

The realist synthesis paper was chosen to be the focus of the journals podcast:
Supporting international medical graduates' transition to their host country: Realist synthesis. Amelia Kehoe interviewed by Kevin Eva for Medical Education, 12 October 2016.

A presentation and guidelines were delivered (to both overseas medical graduates and education leads from a number of Trusts) at the regional induction in order to aid implementation:
Supporting Doctors New to UK Practice Induction. Health Education England (September 2016).

Further impact following dissemination of findings is presented in Chapter 9.

Conferences:

Kehoe, A. *Implementing a programme for overseas doctors*. National Association for Clinical Tutors (NACT UK) – Training the new Generation: A meeting for leaders in Postgraduate Medical Education across the Specialties January 2017, London (oral).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., Carter, M., & Metcalf, J. *How can we support the transition of overseas doctors to the UK?* A realist evaluation. HEENE Future of Medical Education Conference September 2016 (oral).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., Carter, M., & Metcalf, J. *How to implement a Programme for Overseas Doctors: Findings from a realist evaluation.* AMEE Annual Scientific Meeting August 2016, Barcelona (chosen as a research paper, oral).

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Kehoe, A. *How can we support overseas doctors?* Medical Education Development Day May 2016, University Hospital of North Tees (oral).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., Carter, M., & Metcalf, J. *A Programme for Overseas Doctors: Realist Evaluation.* Trust R&D and ELD Conference: Improving Patient Care through Research and Education April 2016, University Hospital of North Tees (poster).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., Carter, M., & Metcalf, J. *A Programme for Overseas Doctors: Realist Evaluation.* HENE Quality conference December 2015 (poster).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., Carter, M., & Metcalf, J. *A Programme for Overseas Doctors: aiding transition into the NHS*. AMEE Annual Scientific Meeting September 2015, Glasgow (poster).

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Kehoe, A., Illing, J., McLachlan, J., Forrest, S., & Metcalf, J. *Evaluation of a Programme for Overseas Doctors (POD) supporting transition to working in the NHS.* The UK Foundation Programme Office conference October 2014 (poster).

Kehoe, A., Illing, J., McLachlan, J., Forrest, S., & Metcalf, J. *A realist synthesis of interventions intended to support overseas medical graduates in their transition to work in another country.* ASME Annual Scientific Meeting 2014, 16th – 18th July, Brighton (poster).

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Chapter 1 Introduction

1.1 Outline

This chapter presents background to the research reported in this thesis, including explaining its significance and original contribution to knowledge. The chapter begins by discussing Overseas Medical Graduates (OMGs) role within the NHS and discusses some of the obstacles that they must overcome, both prior to and during their transition. Interventions that have been implemented are then explored briefly. The Programme for Overseas Doctors (POD), which is the focal intervention of this research, is briefly discussed. The chapter concludes with an overview of the research need, followed by thesis content and structure.

1.2 Overseas Medical Graduates in the NHS

In common with other developed countries, the UK has traditionally relied on OMGs to make up the shortfall between the numbers of doctors it trains and the number it needs to staff its health service and ensure effective healthcare delivery. The most up-to-date figures show that more than a third of doctors (36.4%; n=102,172) registered with the General Medical Council (GMC) have gained their medical qualification outside of the UK[8]. Specifically, 10.9% (n=30,584) qualified in other European countries and 25.5% (n=71,588) qualified elsewhere in the world[8]. It is thought that this number may rise, particularly given the recent crisis in recruitment of doctors to the NHS. It has been suggested that more than two-thirds of Trusts and Health Boards in the UK are trying to recruit from overseas in order to meet the challenge of the current shortage of qualified staff[9]. Between 2013 and 2015, there has been a 60% increase in doctor vacancies[9]. Shortages are most likely to occur in specific specialties (such as General Practice and psychiatry) and in less popular geographical areas[10, 11].

OMGs are attracted to opportunities to work in the UK by presumptions about better working conditions, better medical education, greater career opportunities and a better quality of life[10]. However, this is not always the reality for OMGs[12]. There has, for example, been a growing concern for the last 20 years that poor training leads to doctors returning home disappointed after expending a great deal of effort and expense trying to obtain a career within the UK[13].

1.2.1 Focus of the thesis

'…although different, [overseas doctors] are nevertheless doctors, and therefore the similarities are greater than the differences' (p.81)[14]

OMGs and their transition to their host country is the focus of this PhD. The purpose of this research is not to identify deficiencies of OMGs, but to ensure that this group of doctors are supported to make a successful transition. This is essential for both patient safety and OMG wellbeing. Unfortunately, high profile cases of poor performance have led to negative headlines in the media raising concerns about patient safety (discussed in section 1.3.3). Discussions about OMGs in this context are often framed in negative ways and focus on questions raised about their competency[15]. It has been demonstrated that this causes OMGs to feel they are not trusted or not good enough[11]. Differences in practice need to be recognised, but should not create unnecessary barriers for OMGs. The purpose of this PhD is therefore to provide, based on evidence and theoretical understanding, guidance as to how interventions can aid the transition of this group of physicians. Although awareness about the need to support OMG transition has increased recently, the current situation is still quite concerning.

1.2.1.1 Personal reflection

Before beginning this research, the topic was discussed with a consultant who was relaying stories about his experience working with OMGs. His focus was on their perceived lack of skills. He discussed one individual in detail, stating that he could recognise within the first couple of weeks that the OMG was 'not up to scratch'. When asked if the individual had been inducted, it became apparent that they had not only received no induction, but they had also began their first day on call despite not knowing the hospital. The complaint from the consultant was that the OMG did not know how to do the job. An initial thought was that it may not be their inability to practise which caused these concerns, but rather that they did not understand enough about UK practice. These concerns led to the individual leaving the hospital. For OMGs to be supported they must also be accepted and inducted into the UK system.

1.2.2 International and European graduates: differences

The term OMG is used throughout this thesis to include both European Economic Area (EEA) graduates and International Medical Graduates (IMGs); see glossary of key terms. On occasions throughout this PhD, the terms IMG and EEA will be used separately; meaning that one specific group is being referred to. The terminology of medical graduates outside of the UK is often ambiguous and it is not always clear which group is being referred to. For example, USA and Australia refer to anyone who has graduated outside if the country as IMGs, yet for those in the UK, IMG generally refers to only those from outside of the EEA.

However, some sources do refer to IMG as any graduate outside of the UK. The GMC distinguishes between EEA graduates and IMGs.

Although both have transitional needs[16], it is important to note the difference between the two groups, for example, they differ in terms of how they are viewed by the hosting country; this includes employers, colleagues and patients[11, 17]. IMGs in the UK are put through a much more rigorous assessment than EEA graduates[10, 17]. IMGs are somewhat restricted in the posts that they can obtain, particularly training posts. Under EEA freedom of movement and employment rules, EEA graduates can take up a Foundation level post fairly easily. Training positions will always be filled by both UK and EEA graduates first, creating the possibility that IMGs will only be offered those posts which are left vacant and considered undesirable by UK and EEA graduates[11]. There is no clear guidance on routes to working in the UK. IMGs with temporary migration status face longer delays in their career progression than those with work permits or EEA citizenship[10] (discussed in section 1.4). It is often the case that those employed at a higher level/grade in their own country are taking posts that are well below their level of competence because these are the only posts on offer. Individuals may also come to the UK for a brief period to gain experience through a clinical attachment or training scheme.

1.2.3 Training schemes

In 2009, the Medical Training Initiative (MTI) was developed within the NHS in response to the stricter visa requirements imposed on IMGs in the UK[18]. It was set up to allow IMGs to come to the UK for a maximum of two years and share knowledge, experience and best practice. This scheme is intended not only to benefit the individual and the country that trains them (the OMG is likely to return with more skills), but will provide Trusts with extra doctors to contribute to the work demand. A steady stream of IMGs have availed themselves of the scheme, the majority on Royal College sponsorship schemes being funded by their home country. The funding and push for new posts will come from savings made from a reduction in locum doctors, who are often thought to be of variable quality, expensive and in short supply.

Specific specialties also have their own schemes for training and recruiting OMGs, largely because certain specialties – such as general medicine and psychiatry, rely heavily on OMGs to fill gaps in the workforce[19]. As an example, the General Practice (GP) induction and refresher scheme[20] provides a period of supervised practise that seeks to support applicants and bridge gaps in knowledge or skills in the UK.

1.3 Overseas Medical Graduates' fitness to practise

Despite making up just over a third of doctors, OMGs also account for approximately two thirds of doctors in the NHS struck off each year[15]. The need to develop a better understanding of the factors influencing and underpinning this differential was highlighted in two key reports released in 2011; one from the UK House of Commons Health Committee[21] and the other from the UK National Clinical Assessment Service[22]. These reports sparked concerns about the regulation and professional practice of doctors who qualified outside of the UK. It was illustrated in the NCAS report that non-UK-qualified doctors have higher rates of referral for both assessment and for exclusion/suspension from work compared to UK qualified doctors. Research has also explored the way in which cases involving OMGs were handled by regulatory processes in the UK[23]. The findings supported the NCAS report, illustrating that non-UK qualified doctors were more likely to receive "high impact" decisions at each stage of the General Medical Council's fitness to practise process. Her research took these findings further and illustrated that the referral rates were disproportionately higher amongst non-white UK qualified doctors. One proposed explanation was that real differences existed in fitness to practise between the two groups of doctors, even when factors relating to personal characteristics were considered. Another possible explanation was that the GMC processes tended to discriminate against certain groups of doctors (discussed in section 1.3.1).

Overall pass rates for IMGs in Royal College exams have also been found to be consistently low, particularly in Psychiatry and GP exams[10]. Research has indicated that black and minority ethnic graduates trained overseas were substantially more likely to fail their Royal College of General Practitioners (RCGP) examinations than their UK colleagues[24]. This research showed that 65.3% of overseas-trained GPs failed their first attempt at the Clinical Skills Assessment in 2011-12, compared with 9.9% of medical graduates who studied in the UK.

1.3.1 Prejudices or competency?

Questions about the possible impact of prejudice have been raised regarding the disproportionately high failure rates[25]. It has been suggested that the significant difference in pass rates cannot be explained simply by a lack of competency[26]. Rather, indirect bias and discrimination are thought to play a part in explaining why highly qualified doctors, who have been working in the NHS previously, are failing. An investigation by BMJ Careers also found that white doctors were almost three times more likely to obtain senior posts than ethnic minority doctors (13.8% v 4.8%)[26]. Other research illustrated an interaction of location of

medical education and birth nationality in bias against OMGs[27]. Issues with prejudice and discrimination discussed above could potentially explain the disproportionate referral rates of OMGs to the GMC[10], in comparison to UK graduates. Along with recruitment and assessment bias, a recent study reported that cultural differences and subtle unconscious bias against trainees who did not 'fit the mould' could affect the level of support and encouragement that was needed to learn and develop[25]. However, it is also possible that poorer training quality may cause certain posts to be less desirable, regardless of bias. Since OMGs are recruited to fill these less desirable posts, they may receive poorer quality of training and this may reflect in performance outcomes, possibly explaining why the GP and psychiatry results are lower for this group of doctors.

Between 2010 and 2013, 60% of complaints to the GMC from employers, and 34% of complaints from the public, were about OMGs[28]. This disproportionate number is worth noting as complaints from employers are more likely to lead to an investigation, and therefore sanction or warning, than complaints from the public[28]. The most recent report from the GMC has demonstrated that this is still an ongoing issue, indicating that some groups of OMGs stood out as having had more than double the risk of receiving a sanction or warning[28]. OMGs were more likely to receive a sanction or a warning than UK graduates if the allegation was about professional performance, clinical competence or acting honestly and fairly.

Despite the findings above suggesting prejudices may have led to unfair assessment of OMGs, it is likely that OMG competency levels and previous education may have played some role in the disproportionate findings[24, 29]. A report on the regulations set in place by GMC in April 2014 suggested that OMGs who fulfil the criteria established to assure their competency to practise within the UK may still struggle[30]. It is possible that some OMGs have had poor access to training, but can still catch up and thrive in the UK environment. Alternatively, others may feel completely overwhelmed by the new types of practice and this is where issues may arise[31].

1.3.2 Assessment of IMG competency

The Professional and Linguistic Assessments Board (PLAB) includes a series of tests (highlighted in Table 1) that intend to ensure that IMGs demonstrate the same level of clinical skills and medical knowledge as UK graduates who have completed Foundation year 1 (FY1). However, findings have shown that IMGs who have passed the PLAB examination were more likely than UK graduates to be referred or censured in relation to their fitness to practise[32].

The findings strongly suggested that PLAB IMGs were not equivalent to UK graduates, illustrating poorer performance during Annual Review of Competence Progression (ARCP) compared to UK graduates. Higher scores on the PLAB, above the pass mark, were predictive of an increased likelihood of obtaining satisfactory outcomes during ARCPs, whilst those who took the PLAB multiple times prior to passing were more likely to face eventual censure by the GMC and less likely to obtain satisfactory ARCP outcomes[32].

Table 1. Detailed information about the PLAB test

Entry requirements for PLAB:	➢ A primary medical qualification accepted for limited registration ➢ IELTS (score of at least 7.5 overall and a minimum of 7 for each of the four language skills)
PLAB Part 1:	A three-hour multiple choice examination consisting of 200 single best answer (SBA) questions
PLAB Part 2:	A 14-station Objective Structured Clinical Exam (OSCE). All stations are of five-minutes duration
Pass mark for the PLAB test:	Set to reflect the level that the GMC expect a doctor entering their second year of their Foundation Programme training to be at

Research commissioned by the GMC looked at the rigour of the examinations that IMGs face. Strong evidence suggested that the PLAB examination was, in its previous form, unable to ensure equivalence between international and UK medical graduates' postgraduate performance[32].

The International English Language Testing System (IELTS) is the main route in which IMGs can qualify for entry to the PLAB. Increased overall scores of the IELTS are thought to independently predict a higher probability of obtaining satisfactory outcomes at all ARCPs taken. However, recent research has found that the IELTS is unable to predict professional performance[32].

The GMC have recently raised the pass mark for IELTS, and have extended the scope of the PLAB beyond clinical skills to test professionalism and ethical issues[33]. The practical test, introduced in September 2016, is longer and tests a wider breadth of knowledge and better reflects real-life consultations in the UK health system[34]. Applicants also face limits on the

number of attempts at the test and given a limit of two years to apply for a license to practise in the UK after passing. This is unlikely to eradicate problems associated with OMG transition completely. Transitioning to the UK is about being able to adjust to the different cultural and social norms, not just competencies and language[35].

It is important to note that OMGs can range from those who are only able to work when supervised, to highly trained doctors practicing in specialties. About half of OMGs coming into the NHS are at consultant level, or applying for higher specialist training, and therefore general assessments like PLAB are not always required[13]. There is currently no way of assessing equivalence of overall performance of doctors beyond FY1 level. In contrast, all medical graduates seeking to practise in the USA, whether they graduated in the host country or overseas, must sit the United States Medical Licensing Examination (USMLE)[36]. Having this standardised exam that all physicians must take, regardless of where they qualified, is likely to illustrate equivalence.

It has been argued that attempting to ensure equivalence between UK graduates and IMGs through a test is problematic[31]. Just because they have jumped the same 'hurdle' does not necessarily mean their abilities are the same. Language proficiency is not the same as clinical communication skills, hence more must be done to understand the role that culture, as well as individual attributes such as self-awareness, play. Language proficiency does not mean that individuals can communicate in a culturally appropriate way. Previous cultural practice may impact on how OMGs communicate to patients and colleagues, and perhaps such language exams are not picking up on these differences. Developing culturally sensitive Interpersonal skills have proved a particularly challenging element for OMG candidates, with evidence suggesting empathy and rapport may not be best assessed in simulated consultations[37]. Such areas need to be assessed in practice. It could also be that those with better language skills may be better at defending their practise or presenting better justifications than those with less developed skills.

1.3.3 Assessment of EEA medical graduate competency

Prior to starting this PhD, the clear majority of those OMGs struck off the GMC register or facing disciplinary action between 2008 and 2012 were from international countries such as India, Nigeria, Egypt and Pakistan[38]. Eastern European countries also accounted for a high number of the cases. However, within the last 5 years there has been a significant increase in the proportion of EEA trained doctors under GMC investigation[28]. Recent cases that have been presented in the media have also raised public concern, for example the case of Doctor

Daniel Ubani in 2008, who had previously trained in Germany[15]. Ubani was working his first shift as a locum GP and killed his patient by giving him ten times the recommended dose of pain relief. The GMC is therefore becoming increasingly concerned about EEA trained doctors[35]. There are several reasons why this may be, discussed below.

The population of EEA graduates has grown by far more than that of UK graduates and IMGs[28]. Since a 48-hour maximum week was introduced in the UK in 2010, the number of doctors who trained elsewhere in Europe has risen[38]. There has recently been an increase in migration of doctors from countries facing recession; including Spain, Poland, Italy and Greece[8]. Educational systems in Europe may be different to the UK[35], particularly countries in Eastern Europe which have recently acceding to the European Union, such as Romania and Bulgaria. Both Romanian and Bulgarian medical graduates become doctors of medicine after a 6-year programme, and therefore do not need to undertake FY1 in the UK. If these systems of practice are not of the same standard as those in the UK, graduates may struggle in their transition to a higher level of training[35]. It may be that organisations are not as aware of the issues facing EEA graduates, particularly as this group can take up posts much easier than IMGs[35], therefore have become complacent in assessing their educational needs[11].

Tougher language checks for European doctors came into force in 2015[35], the law now stating that EEA graduates applying to the UK medical register for the first time may have to demonstrate their language skills before being granted licensure. More than 900 EEA doctors were stopped from practising in the UK within the first year of this taking place as they did not demonstrate that they could speak English to the required standard[35]. However, language assessment is only enforced if concerns are raised by employers. No other aspect of competency is assessed due to EU law and regulations. Revalidation is also something that is not required by EEA graduates applying for temporary or occasional status (discussed in section 1.3.4). Until now the issue has not been a cause for concern as the number of doctors applying for temporary and occasional status has been small[35]. However, this is changing and is likely to continue, especially as doctors can now apply online.

Another key change is the introduction of the European Professional Card (EPC), which was introduced for nurses and some health professions in January 2016, and will apply to doctors from January 2018[35]. This will transfer the responsibility to assess doctors from the GMC to the regulator in their home country. This will significantly limit the GMC's ability to scrutinise applications. Some of these doctors may not have practised for many years. Employers must therefore play a part in ensuring OMGs from Europe are competent to practise. GMC

registration tells employers little about the competence of each doctor[35]. This was evident in a recent case presented in the media, involving an OMG who gained his qualifications in Ukraine[39]. The doctor scored zero on some of the knowledge and competency exams that he took for the hearing. He had worked in the NHS for eight years. After he was caught lying about the death of a patient, he was struck off. Employers must therefore make sure that language skills, competency and ability to keep skills up to date are evident. There is limited literature on the experiences of EEA medical graduates working in the UK[17].

1.3.4 Revalidation

Revalidation is a major concern of the GMC[40]. Revalidation was introduced to give greater assurance that doctors are up to date and fit to treat patients. Doctors must justify retaining their license to practice through the preparation of structured evidence, including feedback and reflection. This is unique to the UK.

Reports indicate that OMGs are more likely to defer their date of revalidation[41]. UK graduates have a deferral rate of 8.6%, EEA graduates have a deferral rate of 16.7%, and IMGs have a deferral rate of 11.3%. On a positive note, revalidation has helped to improve the rate of appraisal for doctors not in training posts[30]. This is important, since two thirds of doctors not in GP or specialty training are from overseas[28]. Issues have also been highlighted earlier in this chapter about the potential for bias from local systems or the GMC around the revalidation process of OMGs[30].

The expectations posed by revalidation are likely to prove particularly challenging for those OMGs who are in temporary posts, particularly locums. Locum doctors frequently come from overseas and often 'slip through the net'[42]. Locums are essential to the running of the NHS, as they provide flexibility in medical staffing that aids in overcoming problems around staff numbers or contractual issues. Due to the often short placements, night shifts and rural locations locums are likely to face, they are given less supervision, develop fewer relationships with colleagues and are unlikely to take part in professional development or develop their clinical governance skills[42, 43]. Although locums can be put through revalidation by locum agencies, many are not[44]. It is of importance that these doctors are monitored and offered support.

1.4 Utilising the experience of Overseas Medical Graduates in the NHS

The NHS currently fails to utilise and value OMGs previous experience[45]. Making the best use of such a diverse group of doctors is a complex matter, particularly as there is currently no

standard route for entry. OMG experience is often underutilised due to structural and institutional barriers, for example recognition of qualifications or temporary visas[12, 16]. One piece of research found that 800 OMGs applying for one post and found that those applying spent an average of 11 months out of work, many suffering financial and personal hardships[46]. Medical skills acquired in home countries, at great expense, may therefore be wasted.

As mentioned previously, the UK media often reports stories about OMGs that are open to misinterpretation and have caused concern about competency. The value of these workers can therefore be overlooked. This is despite evidence demonstrating that OMGs are more likely than UK graduates to have a strong work ethic, family bonds, and appreciation for training opportunities[47]. In fact, knowledge and clinical skills of OMGs is often perceived to be higher than those in the UK due to their extensive training[45]. Patient outcomes for those treated by OMGs in America have been reported to be better than or as good as those treated by non-OMGs[48]. By increasing the diversity of the workforce, OMGs also ensure a richer quality of care to patients of minority populations[49]. UK educators should utilise the wealth of expertise and experience that OMGs bring, particularly in areas where ethnic diversity is high. UK graduates are also likely to benefit.

OMGs themselves may find transferring and utilising their knowledge and skills difficult upon arrival[50], however ensuring that OMGs are aware of their own strengths will help OMGs deal with the real differences in clinical and educational practice that exist[16].

1.5 Overseas Medical Graduates in non-training posts

Due to the rigid and inflexible routes into the NHS, OMGs often get stuck in 'service' posts[17]. IMGs may have had to shift their career aspirations to obtain such posts[10-12, 51]. OMGs make up a large proportion of those in non-training posts: around 60%[19]. These doctors have historically been instrumental in ensuring the smooth running of busy hospital departments and filling rota gaps that are hard to fill[19].

Many OMGs take Staff and Specialty (SAS) grade posts after being unable to get onto training programmes. Many of these doctors are working at a senior level and have at least four years of postgraduate training, two of those being in a relevant specialty. SAS doctors are usually more focused on meeting NHS service requirements, compared to trainee or consultant roles. These doctors tend to receive little or no access to learning, development, or preparation for formal leadership roles[52].

Non-standard grade doctors, also known as Trust Doctors, are also a relatively new phenomenon in the UK. They have arisen as a means by which Trusts can employ additional junior doctors. Trust Doctors are employed by Trusts for service and are therefore not regulated by the Royal Colleges or the deaneries (departments of postgraduate medical education). Following the stricter regulations of hours for junior doctors, many more Trust posts were created. Many OMGs are in these posts as a temporary measure to help them to get into specialty training or become consultants. Despite many having practised for a number of years in another country, they need to demonstrate competencies at foundation level before applying to Royal Colleges. Their work is often indistinguishable from that of the training grades yet few Trust Doctors have regular appraisals, and many Trusts lack an organisational strategy for their education and supervision. This hinders career progression[29].

1.6 Difficulties in practise caused by differing cultures and systems

The post-migration experiences of OMGs are complex and not simply understood[53]. Most OMGs face initial difficulties in attaining residency positions, and those who are successful often face further challenges in making a transition[29]. These may hinder their performance in the long-term and ultimately affect patient satisfaction and care. Thus it is important that this is explored further in the UK due to the aforementioned significant reliance on non-UK qualified doctors.

Transition is the process of changing from one state or condition to another; change is at the core of the phenomenon of transition[54]. One of the major barriers in making a transition from one country to another is acculturation, the psychosocial adjustment and adaption to a new culture for those from another culture[2]. It is a multidimensional process of change that occurs when individuals from different cultural groups are in continuous contact with one another. Adaption depends on how individuals deal with this change and adapt to the dominant society. This is an extremely important issue as a majority of IMGs come from the Indian subcontinent and from cultures where practice is very different[10, 55]. Those whose home cultures were very different were found to experience the greatest difficulty adjusting to working life in the UK[50].

1.6.1 Culture

Hofstede refers to culture as the way people think, feel and act, defining it as the collective programming of the mind that distinguishes members of one group of people from another[56].Organisations must be aware of and understand the differences in cultural norms

in relation to training and practice so that cultural competence is increased amongst supervisors and colleagues, aiding in the support offered both initially upon arrival and ongoing during practise[57]. The diverse challenges resulting from cultural differences must be acknowledged as these are likely to be related to OMG transition[25]. The UK health system is also widely regarded as less hierarchical than many systems in many countries from which IMGs originate[58]. Personality and gender differences may also play a key factor in acculturation experience, particularly if religion is added into the equation[50].

Hofstede created a model to measure aspects of culture, so that countries could be compared, based on four dimensions including power distance, individualism, masculinity and uncertainty avoidance[56]. Power distance relates to the extent to which power is distributed, from equal (small) to extremely unequal (large). In small power distance societies (such as the UK) patients treat doctors as equals, there is less of a hierarchy between colleagues, employees are not afraid to disagree with seniors, and initiative is expected. In contrast, large power distance cultures (such as India) place great emphasis on hierarchy, employees are reluctant to disagree with seniors and teachers take the initiative. In terms of the doctor-patient relationship, patients from larger power distant cultures (such as Asia) will treat the doctor as superior and discussion is controlled by the doctor.

Individualism refers to the focus of the individual on themselves (and immediate family) rather than collective behaviour, in which people are integrated into strong cohesive in-groups. Collectivist cultures are more likely to place emphasis on 'learning how to do' rather than 'learning how to learn' in individualist cultures. Collectivist cultures may lead to doctors being less assertive and less likely to speak up to supervisors.

Masculinity refers to ambition and values (ranging from assertive and competitive to modest and caring), whilst feminine cultures are more concerned with quality of life and process in comparison to outcomes[56]. Those from masculine cultures are likely to try to make themselves heard in class, over-rate their own performance and compete with one another. In feminine cultures, weaker students are often praised in order to try and encourage them rather than focusing on high flying students.

Finally, uncertainty avoidance refers to the way in which a culture manages uncertainty and change. In strong uncertainty-avoiding countries, people tend to be more expressive and in terms of the doctor-patient interaction, less emphasis is placed on rapport building. It is also likely these countries spend more money on doctors rather than nurses, therefore more

tasks are done by the doctors themselves. This culture can also result in a more structured learning environment where the teacher is seen to have all of the answers and students are only concerned about these. In weak uncertainty-avoiding countries, the expressions of feelings are repressed and there is greater tolerance of opinions (such as in the UK).

Rothwell *et al* (2013)[59] found further areas of difficulty, including staff relations, teamwork, and practical and logistical difficulties (e.g. accommodation, finance, family circumstances). For OMGs, immigrating to a new country also means adapting to differences in disease patterns, levels of technology, administrative duties, treatment options, forms of health care delivery, lifestyle, gender roles, and in some ways, status[58, 60, 61].

These differences in cultures and jurisdictions will undoubtedly impact upon ethical decision making in health care[29]; examples of such issues arising including consent, information sharing, end-of-life decisions[62] and the role of family members[63]. Without the necessary support, these individuals will be heavily influenced in their decision-making by the norms in their own country[64]; a lack of understanding and awareness of the standards set in the UK may lead to severe consequences for both the doctor and the patient. The lack of relevant information about legal, ethical and professional standards/guidance prior to starting work is evident particularly for those not in a training post[11].

1.6.2 Intercultural communication

Communication difficulties were found to be a key factor behind higher failure rates amongst OMGs[10, 37]. Researchers found that those candidates whose English is influenced by other languages, for example those who spoke Indian English, often sounded formulaic due to their use of intonation and other patterns of speech which may differ from those used by local English speakers[37]. Difficulties in understanding local words, colloquialisms, expressions, and accents are also likely to pose a problem when communicating with both patients and colleagues[10]. As well as language barriers, challenges are posed by different styles of communication and prejudices. It is not uncommon for patients to reject care provided by overseas graduates due to perceived inefficiency in communication skills[65]. It is this perception that can lead to a belief of incompetence by patients, peers, and other health professionals; ultimately impacting on job satisfaction and retention[66].

Linguistic competence is only one component of many elements of overall communication competence. Communication includes non-verbal skills that are particularly influenced by cultural differences. Intercultural communication is a type of communication that aims to

share information across different cultures and social groups[67]. OMGs do not always receive adequate training or receive appropriate feedback on their communication skills, as illustrated in a study by Searight *et al* (2006)[64], where OMGs reported 'We had no formal training. Nobody taught me how to talk to patients' (p.167). OMGs also reported differing experiences with how much emphasis was placed on a good doctor-patient relationship in their previous training, some doctors reporting 'There is no doctor-patient relationship' (p.167). Standardised tests such as PLAB aim to screen for communication barriers, however these do not appear to guarantee effectiveness in practice.

1.6.3 Impact of poor acculturation

The process of acculturation, which is acknowledged to be stressful, can be associated with social and psychological problems[10, 68]. Studies have reported post-migration experiences to be linked to poor psychosocial well-being, such as low self-esteem, disappointment and demoralisation[12, 69-71]. Positive OMG role-models can help to create aspiration and may be one of the best solutions to a overcoming a sense of embitterment and injustice[16]. Bourne *et al* (2015)[72] also illustrated that doctors who experience or observe complaints processes are at risk of suffering from depression, anxiety and suicidal thoughts. In addition, 'hedging' (increased defensive practise) and avoidance behaviours are also likely to follow complaints, which may be damaging to patient care.

1.7 Interventions to support transition

The situation that OMGs face as they join the NHS generally contrasts strongly with their previous experiences; particularly in the clinical context and nature of practice, and thus the initial few weeks are critical in ensuring that an adequate adjustment process begins. OMGs are likely to need more help and more time than UK graduates to adjust to their new work environment and so this should be explicitly acknowledged. Esmail stated in an interview: "Why can't we then accept that the deaneries need to put more resources into these areas because we need these graduates? We recognise that they may not be as good as UK graduates, so let's do something about it. It's really as simple as that" (reported in the BMJ)[33]. Esmail argued that people involved in the regulation and training of doctors need to be open about the differences between UK graduates and OMGs. If these individuals can be matched to appropriate training then outcomes are likely to improve and the gap caused by differing starting points may be minimised. One systematic review argues that trainers, deaneries and colleges must plan and develop strategies to enhance the potential of OMGs[10].

The differences between orientation and transition interventions (or programmes) are often not recognised and the terms are used inter changeably. Despite being related operationally and conceptually, they are in fact different (induction is used as a term for orientation). Orientation aims to introduce staff to the goals, policies, procedures and expectations that will allow them to function in a particular work setting[73]. Healthcare providers usually implement a general orientation and a unit orientation. General orientation requires all new staff, regardless of position and work unit, to attend to gain knowledge about institutional policies and procedures. Unit orientation only covers unit-specific policy and procedures. Discussions with OMGs prior to conducting this research highlighted that these general inductions are lacking information and are unhelpful.

A transition programme in comparison is a formal programme of teaching and learning designed to facilitate and support the transition into a new work environment. Orientation may be a part of this transition programme, but generally transition programmes are longer, more comprehensive and specific. They often involve competency based learning. Therefore, regulatory bodies must take this into account, inductions perhaps not offering adequate support for transitional outcomes to be achieved[74].

1.7.1 Support

It is unreasonable to expect OMGs to adjust instantly to a new culture and new practice without help and guidance[13]. Research illustrates the need for a greater amount of support from employers and a more timely and comprehensive procedure to be undertaken during the transition process to ensure OMGs have successful adaptation to the UK healthcare system[29, 43]. This is particularly important following the findings that a high number of OMGs reported mental health problems because of work[25]. The absence of a supportive framework that targets social, cultural and work-related issues, can lead to feelings of loneliness, stress, low self-confidence, alienation and social isolation, a decrease in social status, negativity, and anger when entering new medical workforces[16, 29, 75]. A link between social support and mental health is evident[76]. Specifically, fewer relationships, smaller networks and lower perceived adequacy of support may also be related to depression. Given that OMGs are more likely to be separated from family; have poor work-life balance; and have little support outside of work[25]; this is important. Social support is the provision of psychological and material resources intended to benefit a person's ability to cope with stress[77], this being key in transition. Each individual hospital will have its own culture and therefore the level of support offered will vary. OMGs often move between hospitals, particularly if working as a

locum, and so it can also be hard to build trust and feel part of a team. Issues resulting from stereotyping could also impact on the support offered. OMGs may face difficulty adjusting to their new social environment and interacting with co-workers and patients as a result. Cultural awareness training for peers and teams would therefore be beneficial[78].

1.7.2 Supporting the different stages of transition and differing needs

Couser[74] recognises that designing interventions for OMGs is a complex task, and interventions must be tailored to individuals and local conditions. Rothwell *et al* (2013)[59] highlighted the different approaches needed when addressing the challenges faced by overseas doctors, different methods being appropriate for differing issues (perhaps work-based not knowledge-based) and being relevant at differing stages of the transition. They suggested differing interventions at each stage of the doctor's transition; before moving to the UK (focusing on language, knowledge and information issues), at the point of transition (focusing on integration between staff, knowledge and cultural issues) and ongoing workplace support (focusing on relationship and work adjustment issues). Recommended interventions for OMGs transitioning to the UK included provision of educational resources before starting work, support in practise including longer shadowing, targeted NHS induction, practical support for social issues, language and cultural training to target acculturation, communication skills training, and buddying or mentor schemes for training and social support[2, 29, 43, 78].

Although most intense at the start, adjustment will be lifelong and OMGs may still encounter shocks each day[47]. Culture shock may occur in the realisation of being in a different culture with different values, some individuals adapting better than others. Those that struggle to adjust may act in ways that are not appropriate and therefore such individuals will require ongoing support in facing culture shock so that they can adjust their behaviours[79]. Differing language and cultural challenges may also lead OMGs to encounter difficulties in learning[10], therefore learning experiences must be individualised[80]. OMGs could take months to acclimatise to a new working environment[10]. OMGs routinely report the failure of their employers to take their transition needs into account when designing their individual learning plans[16].

As discussed previously in this chapter, differing levels of training and support are offered depending on the post obtained, for example those on foundation training programmes will receive much more support than those filling Trust Doctor posts or coming in at a higher level. The foundation programme provides generic professional training to bridge the

transition from medical school into specialist and General Practice training[81], hence OMGs starting this training will benefit from the content and level of support[2]. However, even UK graduates at this level face difficulties regarding practice[82], foundation doctors in general having been found to feel inadequately prepared and often feel they have been asked to perform tasks beyond their capability[83]. Support is set to increase for graduates in training posts from 2016[28]. However, the proposal is likely to still lack enough specific support for OMGs who do not have the same educational background to build on and are likely to experience more challenges in their transition than UK graduates[82, 84]. MTI participants are also at an advantage in terms of support in their transition to the NHS as the schemes must include a period of monitored clinical supervision and an induction specific to OMG needs[18]. For those starting the GP induction and refresher scheme, E-Learning resources are available and mandatory GP induction modules must be completed prior to acceptance[20].

1.7.3 Current interventions (within the UK)

Internationally there has been significant government attention and funding directed towards the induction, supervision and mentoring of OMGs (see Chapter 4 for full details). Within the UK, the GMC has implemented a Welcome to UK practice (WtUKP) induction[41]. Postgraduate deaneries run induction courses, however focus is on those in training posts. Some of the colleges also implement their own support system or training programme. Those that are inducted within the employing Trust receive varied inductions. The GMC do recommend that all OMGs should attend an induction programme, however it is evident through discussions with Trusts in the North East that many do not. The extent of current uptake of interventions offered is unclear[11]. Difficulties arise due to the varying recruitment pathways to starting work in the UK[11]. Furthermore, induction programmes are often brief, happen before employment and are presented didactically[45, 85]. Differing perspectives of needs was also illustrated in a Canadian study; highlighting the different perspectives between OMGs and Programme Directors[86]. This seems to be one of the main difficulties implementing a structured formal intervention[87]. This may explain why OMGs within the UK have stated that interventions are lacking and that support from their hospital or Trust was not adequate enough to ease their transition or help them progress[11, 45]. Acculturation and social networks are likely to develop with the passage of time. Where OMGs within the NHS were exposed to information (for example about NHS system, culture or career progression), and support (whether from peers, supervisors, or family), they were more satisfied and confident in their work[45].

Some deaneries within the UK have started to look to others countries for guidance. As an example, E-learning modules were developed in the London Deanery for supervisors, to help them provide effective support to OMGs. Their approach drew heavily on a comprehensive well-researched intervention implemented in Canada[88]. Other countries also place more of an emphasis on attachments or internships. One Canadian Trust provided extra coaching and a specific training site for IMGs to train alongside Canadian graduates[89]. Their findings illustrated no statistical difference between IMGs and Canadian graduate performance, potentially as a result of this training. IMGs often use clinical attachments in the UK to secure training posts[90]. Although they may help to initially learn about the culture and ethics within the NHS, research suggests that the success of these attachments may be limited[90]. There is currently no structured process for recruitment, guidelines for implementation and supervision is lacking, there are no methods for regulating the quality of the attachments, and little information is made available to IMGs about applying for such positions[90, 91].

The GMC recognise the need to make sure induction is consistent for all doctors[45], however employers also need to know what they should be delivering. On many occasions OMGs are not even given a general NHS induction. It is not clear whose responsibility it is to provide the support that is lacking[11].

1.8 Uncertainty within the NHS

Up until near submission of this PhD, the impression had always been given that doctors who qualified in EU countries faced an 'easier time' than those from international countries. The NHS had taken for granted that doctors could move freely within the EU, without the need for substantial amounts of paperwork and formalities. However, following the June 2016 referendum, in which it was decided that the UK would withdraw from the EU (Brexit), there is considerable uncertainty facing this group of doctors. Following Brexit, the UK will likely introduce new legislation that will lead to a greater emphasis on documentation and rigorous assessment process for EU workers. It may also affect rights whilst working in the UK.

EEA workers currently employed in the UK are undoubtedly experiencing a sense of uncertainty as a consequence of the referendum result[33]. Concern has also arisen with regard to Jeremy Hunt's plan to make the NHS "self-sufficient" with home-grown medics[92]. Despite many believing that this poses "a major risk" to the health service, the announcement affected morale and led to OMGs feeling insecure and that they may not be as valued as UK doctors[92].

Self-sufficiency is unlikely to work for a number of reasons. At present, many UK-trained doctors do not feel valued[92]. A high number of junior doctors are planning to move, or have moved, overseas following the decision to impose a new contract for junior doctors in May 2016[93]. As a result, concern has been expressed about the impact that this low morale will have on patient safety[93].

This comes at a time when the number of OMGs coming to work in the UK is falling and the number leaving the UK is rising[94]. Of the 9000 doctors who gave up their licence to practise between 2013 and 2014, around 40% were OMGs; the majority being from South Africa and India[28]. New immigration laws are likely to have affected this. The number of EEA graduates on the GMC register has also dropped by about 6% within the last year. This percentage will likely rise as OMGs working as junior doctors are likely to be disproportionately affected by changes to the contract[19]. The latest figures provided by the GMC reported that the number of OMGs starting foundation training, both IMGS and EEA graduates, has decreased in the last year[8].

Consequently, there are substantial gaps in rotas and appointments are not being filled[9]. Locum doctors are having to fill these gaps as much as possible. Therefore, the plan to train more UK doctors and stop recruiting from overseas is not likely to fully address the staff shortages. Some specialties such as GP recognise this and therefore have recruited hundreds of GPs from countries such as Poland, Lithuania and Greece ahead of Brexit[95]. Through discussions with local Trusts in the North East, it has become apparent that many Trusts and Colleges throughout the UK are planning to do the same. This highlights the wider implication of this PhD and ensuring OMGs are supported adequately in their transition to the UK, since they are likely to be relied upon even more so in the near future.

1.9 Summary

This current work is not suggesting that OMGs as a group are incompetent or unsafe, but that they experience challenges during the transition phase that need to be considered as they can have direct implications for quality of care and safety of patients[96]. It is possible that the higher proportion of OMGs referred for disciplinary proceedings could be due to a lack of medical competencies required within the UK for safe practise, but it is also possible that many of the cases result from cultural, communication and ethical differences[29, 32]. Since 'equivalence' between OMGs and UK graduates may not be achievable through entry assessments, society will continue to decide on the levels of clinical skills and professionalism deemed acceptable[32]. A lack of support with adjustment issues may therefore, to some

extent, explain the over-representation[23, 59]. The way in which doctors progress is dependent on each organisation, their approach to learning and the support system they offer[25].

Referrals not only raise patient safety issues, but the cost to the NHS due to investigations, exclusions and suspensions is significant. Interventions to support transition will likely be cost effective in the long run due to increased performance, patient satisfaction, and higher retention of doctors. Specific educational, cultural and practical needs of OMGs can be addressed by training programmes and support interventions[75]. It would be beneficial to introduce preventative measures rather than resolve issues after they have occurred.

1.10 Initial pilot of the Programme for Overseas Doctors (POD): developed prior to PhD

Some NHS organisations have identified the need for a structured support programme to support the transition of their overseas doctors. One North East NHS Foundation Trust developed and piloted an intervention for overseas-qualified doctors to ease their transition into working in the NHS (note: when talking about specific hospitals, pseudonyms will be used throughout this thesis to anonymise the individual sites as much as possible).

The aim of the intervention was to aid in the development of NHS cultural values, increase communication skills, and ultimately improve performance and increase patient safety. A steering group for the intervention was set up at Amity Hospital (AH). This group consisted of Educational Directors, Tutors, Clinicians, Programme Leads, Administrators, OMGs, and myself as a PhD researcher and programme evaluator. A five-day induction programme was developed, including topics such as local cultural issues, social issues, linguistic/ communication skills and patient safety, expectations, governance and structure of the NHS.

POD ran before foundation year shadowing in July 2013. Participants all rated the scheme highly and it was well received by the Trust. A second induction was run in May 2014 (described in Chapter 3) and was oversubscribed, highlighting the popularity of this intervention. It was hoped that such an induction could be embedded in the Trust and continue to run in the future. AH have funded the current project to deliver a rigorous evaluation of the intervention and support in the implementation and development of the intervention. The North East of England has issues with recruitment and retention and it was hoped this intervention would address this and contribute to the development of joint resources for future years. This Trust was the first to roll out the developed intervention

before feeding back the findings to Health Education England North East (HEENE); who are currently in the process of developing regional interventions.

1.11 Research need for this project

Although research has led to recommendations concerning the transition of OMGs, research into education for OMGs is currently underdeveloped[43, 53, 97, 98]. Implementation of educational interventions for OMGs is lacking[99]. A hand search of reports prepared by NHS Trusts led to the conclusion that very few individual Trusts across the UK implement specific interventions for overseas doctors (discussed in Chapter 4). Most deaneries across the UK have been advised by the GMC that they need to provide induction programmes for OMGs, however these vary in terms of length and scope[53]. Many are not comprehensive enough to address all the challenges facing OMGs. Interventions are often designed based on deficiencies in medical knowledge and skills[99]. Combined with the probability that educators do not have specific experience with the needs of OMGs[88, 100, 101], this can pose problems.

The GMC has recently evaluated their pilot induction for OMGs, however information obtained was limited as the evaluation was satisfaction based. A recent systematic review of educational interventions for IMGs strongly supports the need for better evaluation and highlights the need for a theoretical approach to reviewing interventions for OMGs[53]. The study highlighted the diversity of interventions and weaknesses of methodologies used to date. Only one study referred to a theory to guide curriculum development. The outcomes were primarily inferred by the authors as positive or supportive of the intervention. Research is needed to provide clear guidance on the most effective ways to support OMG transition, both theoretically and empirically[53, 97, 102]. This thesis seeks to address these needs.

Given the complexity of OMG challenges and their transition, interventions are likely to be context dependent. Generalisations cannot always be made from experimental research approaches. Lineberry *et al*[53] suggested that research should employ conceptual frameworks to facilitate a broader, more nuanced consideration of OMGs diverse needs, interventions, medical and educational contexts and outcomes. This PhD is the first piece of research to explore OMG transition in this way.

Overall, this thesis explored and evaluated how interventions were successful in supporting OMG transition to the UK, thus informing current interventions through evidence-based recommendations. It is hoped this this will lead to a clearer concept of what interventions should be implemented for OMGs, highlight what contextual barriers must be addressed,

and illustrate the necessity and benefit of such structured induction and support programmes within Trusts. This research intends to add to knowledge about both OMG transition and realist methodology.

1.12 Aims and objectives

Aim

- To explore and evaluate interventions that have been developed to support the transition of overseas medical graduates to the UK

Research Question

- How do interventions, set up to support overseas medical graduates, support them in making a successful transition to the UK workplace?

Objectives

- What interventions and services are provided to support the transition of overseas medical graduates to the workplace?
- What barriers may hinder implementation of interventions?
- What were the outcomes of not having adequate training and support interventions in place?
- How and why are interventions effective (or not effective)?
- What factors are vital to the success of the intervention?
- What barriers may hinder transition and how can they be overcome?
- What are the theoretical explanations that may be applicable?
- How can interventions be developed and improved for future implementation?

1.13 Thesis structure

The thesis draws together findings from the research project, led by and feeding into overarching middle-range theories (see next chapter). Due to the nature of the realist approach adopted, elements of the methodology will be described across several chapters. The process of realist evaluation is highly iterative. Thus the overall design of the project was directed by each phase. The PhD is comprised of two main phases; a realist synthesis and a realist evaluation. The structure of the thesis is highlighted below.

Chapter 1 provided an overview of the current state of OMG transition and explored the need to provide further support. Chapter 2 explores the realist approach that was adopted

in this research. Chapters 3 and 4 illustrate how an initial framework was developed and refined through a realist synthesis. This was then used to feed into data collection and analysis.

Chapters 5, 6, 7 and 8 forms the empirical study. Chapter 5 presents the methodology. Chapter 6 discusses key contextual factors of the case study sites included in the research. Chapter 7 is the first of two data chapters, which presents findings from the evaluation. A refined intervention is also presented. Chapter 8 then presents findings from the evaluation of the refined intervention and explores the emerging programme theory even further. This involved a synthesis of the findings from the above components. The final chapter (9) discusses the findings in relation to the literature reviewed, its contribution to medical education and theory, and the strengths and limitations of the research. An agenda for future research, impact of the findings, and reflections are also presented.

Chapter 2 Realism

2.1 Outline

This chapter discusses the theory-driven approach of realism used within this research project. It provides a background to realism, exploring alternative philosophical perspectives to understanding complex phenomena, and defining terms and methodology. The chapter concludes by explaining why a realist approach was deemed the most appropriate for this piece of research and outlines the methodology that is then presented fully in subsequent chapters.

2.2 Understanding research paradigms

As a researcher, it is essential to understand the different research paradigms that exist so that your own perspective, and approach, can be placed within these and understood. A paradigm is a set of common beliefs and agreements about how problems should be understood and addressed[103]. According to Guba *et al*[103], research paradigms can be characterised through their ontology (what is reality?), epistemology (how do you know something?) and methodology (how do you go about finding it out?). These characteristics will be explored for the different perspectives discussed below.

2.3 A background to realism

Realism is a school of philosophy that sits between positivism (there is such a thing as a real world, from which we can derive 'facts' from through direct observation) and constructivism (since all our observations have been interpreted and shaped through human senses and the human brain, it is not possible to know for certain what the nature of reality is)[104]. It is not a simple matter of choosing one paradigm over the other. Realism assumes that social systems and structures are 'real' and that individuals respond differently to different interventions in different circumstances[105]. This is the place in which this research sits; crossing over the two paradigms and therefore utilising the power and strengths of both.

2.3.1 Positivism and its relationship to realism

Within social sciences, positivism holds the view that there is a natural scientific world that we can observe. Ultimately, we can have direct access to the real world; there is one single external reality. This ontology can be termed realism.

It is the core belief that when conditions are manipulated they can result in measurable outcomes (cause and effect). It is assumed that it is possible to obtain hard, secure, objective

knowledge[106]. Therefore, we should be able to predict these outcomes. Positivism seeks to discern natural laws and determine universally applicable truth from a particular situation through experimental testing and hypothesising[107]. Experimental approaches, using statistical analyses, are used to examine the reliability and accuracy of the sample (often controlling for variables). Reliability is the consistency or repeatability of your measures. This reduces the variance of estimates of the treatment-effect in order to lead to larger scale implications of the findings. When taking a positivist approach, the role of the researcher is limited to data collection and interpretation through an objective approach. The researcher positions themselves as independent from the study. A deductive approach is usually adopted; hypotheses are tested in experiments. Repeatability is critical to a positivist approach, research focusing on generalisation and abstraction.

Although conditional statements of probability are useful, the rules of positivism are problematic in social sciences[108]. Realists would argue against the idea that all that can be learnt about the social world can be observed and is of an empirical nature[109]. Instead, social phenomena are more complex. Realism is not entirely dissimilar to positivism, for example the focus on hypothesising and causation. However, it is argued that the reality of causations and outcomes is independent of our knowing it and we can never fully account for real social phenomena[108]. Positivists are objective and do not place importance on reasons for the cause of observable actions (e.g. unobservable mechanisms at play). They aim to remove the bias of humans, but fail to take into consideration human experience and the context of which they are a part.

In the case of social interventions, the concern is with effecting a change in a regularity (pattern). A pattern of behaviours may be problematic for a whole variety of reasons. Change in behaviours depend on whether interventions provide the necessary resources or change in context[105]. Positivist approaches do not fully explore this complexity. They are unable to determine which interventions do, and which do not, produce both intended and unintended consequences. This limits the lessons learnt for policy and practice in the social world[110]. It is not possible to predict how each individual will respond to an intervention without knowing more about the context.

2.3.2 Constructivism and its relationship to realism

Constructivism is one example of an anti-positivist perspective. It posits that there is no single external reality. The ontology of constructivism is relativism, which states that reality

depends on individual perspectives, which all differ[108]. We may become more informed, but this does not help us to develop knowledge that has the status of universal truth.

Anti-positivism asserts that objective knowledge of the world around us is not fully accessible and that it is imperfect, seeking to establish the most likely truth. We can only understand it through perceived knowledge. Research focuses on the specific and concrete, therefore constructivists seek to understand phenomena in specific contexts[106].

Pawson and Tilley[5] illustrated the weakness in constructivism; a lack of ambition and hesitation in commenting beyond the sample studied. Constructivists are sometimes viewed to have failed in recognising that many structures are indeed similar between contexts. In contrast, positivists aim to generalise findings, ignoring the potential influence of contexts. Realism very much focuses on context, but takes this a step further by illustrating what patterns may be applicable in other environments.

In constructivism, the researcher's position and interpretation can be critical to the analysis of information; meaning being constructed through the interaction of researcher and participant. Anti-positivist perspectives can be more appropriate than positivist paradigms in medical education research, as an aim is often to develop an early understanding of a topic, particularly if current understanding is at an exploratory level. These approaches can also help to understand the context in which the findings may or may not be applied.

2.3.3 Critical realism

Another example of anti-positivism is critical realism, which states that reality cannot be truly known due to human nature and the complexities of the social world around us[108]. As stated earlier, the epistemology is comparable to positivism in that it is still objectivist. Objectivity is still the ideal but claims are tempered. Mixed methods are often used by researchers. Knowledge is built by adding new knowledge to old, but unlike positivism it recognises the difficulty in accessing reality.

Bhaskar[111] argues for critical realism, stating that the world is structured, differentiated and changing, and we should not deny the reality of events: in fact, we should insist upon them. It was felt that we will only be able to understand, and therefore change, the social world if these structures at work are identified. Bhaskar pointed out the rooted philosophical errors in positivism and reasserted realism's potential for guiding us to improve the way in which we obtain knowledge. Science must be aligned to the task of addressing problems in the real world, reaching beyond the limits of empiricism and grasping a deeper and more productive

understanding of the world through abduction. This is particularly important in medical education, where simple and linear causality is unlikely[112].

2.3.4 Realism in recent times

Realism, much like critical realism, is also a way in which we can seek to understand the social world around us, acknowledging the external social reality and the influence this has on human behaviour. Recently, individuals such as Pawson and Tilley[1] have taken Bhaskar's proposal of critical realism a step further. They assert that behaviour is not exclusively governed by social structures; individuals are also able to transform social structures by responding creatively to the circumstances in which they find themselves[1]. Realist approaches hold the ontology of positivism (realism), and epistemology of constructivism; there is a real world independent of our knowledge and perceptions of that world (realist ontology), but acknowledges that our understanding of it is a construction from our individual perspectives (constructivist epistemology)[112]. It is believed that the 'real world constrains the interpretations we can reasonably make of it' (p.91)[113], social structures providing resources that enable individuals to act in a certain way, as well as limit their behaviour. Therefore, we can never know for sure whether we have depicted reality as it actually is[108], however we can improve our understanding of this reality.

Realists see social phenomenon to be stratified in some way, with mechanisms (that are often unobservable) affecting the observable phenomenon that is being studied[108]. For Bhaskar and critical realism, these causal mechanisms sit primarily within the structural component of the social world, but for Pawson and Tilley[5], mechanisms are identified at the level of human reasoning[4]. Outcomes will be the result of the reasoning and responses of the participants, rather than reside in the resources and power that lie with the great institutional forms of society.

The key feature of realism is its stress on the 'mechanics of explanation' that can lead to a 'progressive body of scientific knowledge' (p.55)[5]. In comparison to critical realism, this therefore offers more explanatory power when dealing with complex interventions (see Box 1 for definition of complex interventions). Wong *et al*[113] also add that complex interventions do not act in a linear fashion, are reliant on the people carrying out the intervention, and are highly dependent on the context in which they take place. Realists would direct us to think in productive ways about complex problems and create positive developments in the world around us.

Box 1. Dimensions of complexity given by the Medical Research Council[114]

What makes an intervention complex?

- **Number of and interactions between components within the experimental and control interventions**
- **Number and difficulty of behaviours required by those delivering or receiving the intervention**
- **Number of groups or organisational levels targeted by the intervention**
- **Number and variability of outcomes**
- **Degree of flexibility or tailoring of the intervention permitted**

2.4 Impact evaluation

Policy makers and evaluators are concerned with understanding how to design interventions that will have the maximum impact[115]. Traditionally, the focus of evaluative inquiry has been outcome-focused approaches, which aim to assess the impact and effectiveness of interventions in achieving the desired outcomes[5, 116]. However, in recent times, the issue in question has progressed from that of 'does it work' to 'for whom' should we offer the intervention, and 'how might we maximise its benefits?'[113]. These questions therefore raise the issue of causation: for example, how are the benefits generated and why does the impact differ between individuals?

Many interventions cannot be evaluated through traditional outcome-focused approaches, which identify linear, causal relationships between the intervention inputs and observed changes in clinical outcomes or practice[117]. Interventions may already be in place before an evaluation is proposed, or may have been rolled out simultaneously across different areas, and so gives little opportunity for a control group[118]. Large-scale, complex interventions also require deeper insights into the nature of the intervention and implementation context[105]. Evaluation in these cases need to focus on how well the intervention is implemented, how the components interact, and what leads to successful (or unintended) outcomes, not just whether they work or not[118]. Interventions are often implemented into pre-existing and complex social systems. Organisations like those in the health services face frequent change and are affected by issues of reorganisation, and changes in policy and clinical guidance. Limited resources, and changing demographics and health needs, are further issues that are likely to impact upon intervention implementation.

2.5 Realist evaluation

Realist evaluation is a form of theory-driven evaluation[105], based on the realist philosophy discussed above. It seeks to understand what works for whom, under what circumstances and how[5]. Interventions represent ideas or theories, often created by those who develop and implement them, about the way in which outcomes can be achieved. The task of realist evaluation is to identify the core theories (programme theory) about how the intervention works and then test these to see if they are valid, practical and plausible. Building theory involves exploring mechanisms that are likely to operate, the contexts in which they might operate and the outcomes that will be observed if they operate as expected[104].

Realist synthesis, also known as a realist review, is a 'systematic, theory-driven interpretative technique' that has emerged as a strategy for synthesising existing evidence[119]. It is used to compare differing cases in the literature, including both primary and secondary data, to explain and understand how and why the observed outcomes have been found[113]. A realist synthesis assumes that a particular intervention (or class of intervention) will trigger certain mechanisms differently depending on the context. The fundamental purpose is to improve the thinking that goes into the delivery of interventions.

Theoretical explanations that are constructed through a realist synthesis (secondary data) or evaluation (primary data) are referred to as 'middle-range theories' (i.e. Contexts, Mechanisms and Outcomes, which are discussed later). Middle-range theories fall between grand theories (how the intervention is expected to work) and the research data[108]. Initial theories may originate from various sources: social science theory; results of previous evaluations; discussions with policy architects and practitioners; and common sense. Middle-range theories account for observed patterns in the data, accommodate any exceptions found, and build on current findings in the field. Although they involve abstraction, they are seen as 'close enough' to observed data[120]. Theories can then be tested and refined further through an iterative process and using empirical data.

Within the configuration, context refers to the conditions in which an intervention is introduced that either enable or disable the process of the intervention mechanisms[118]. Mechanisms are defined as '…underlying entities, processes, or (social) structures which operate in particular contexts to generate outcomes of interest'[7]. Mechanisms refer to the process of how people interpret and act upon the resources offered by the intervention and their reasoning in response; how they put their choices into practice. Mechanisms are not visible and must be inferred from observable data[113], these mechanisms only being activated

in the right conditions (e.g. increased self-awareness following feedback during communications skills training). Realist evaluators therefore view mechanisms and context as being intertwined, thus we cannot ignore the impact of context in evaluation. Outcomes refer to the consequences of interventions, either intended or unintended, resulting from the individual's response (mechanisms) in differing contexts[118].

The model presented in Figure 1[4] was chosen to explain the realist approach used in this thesis as it aims to reduce confusion around the Context, Mechanism, Outcome (CMO) process. It helps to prevent the risk of misinterpretation of the intervention as context. Instead, resources change the context. The model clearly demonstrates the interaction between resources (provided by the intervention; enabling or motivating participants to make different choices), which are introduced into pre-existing contexts[105], and a change in reasoning or response (mechanisms triggered; whether participants make different choices)[105]. This will then alter the behaviour of participants, leading to the observed outcomes.

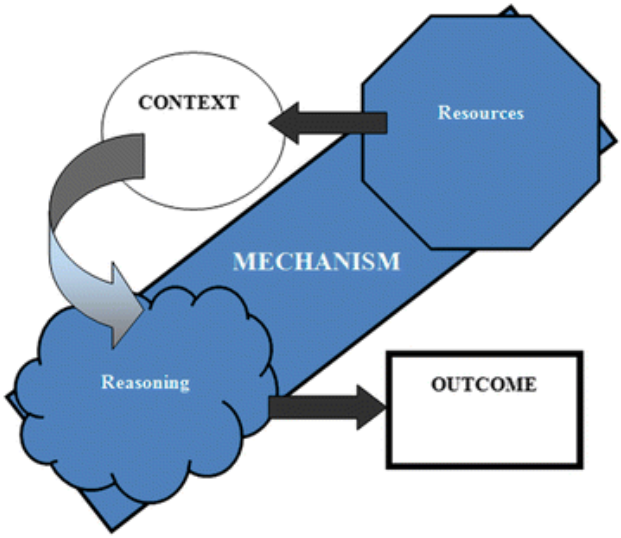


Figure 1. Dalkin et al model[4] – A Context Mechanism Outcome (CMO) framework

Realists argue that it is impossible to measure the impact of an intervention due to the complexity of the CMO interaction, findings from one iteration of an intervention not being generalisable to populations outside of the context and population of that intervention. Thus, we can only ever make imperfect and slow progress in gathering knowledge of the potentially vast number of possibilities that may shape the process[4]. Furthermore, mechanisms of social change may be ongoing, structures shaping actions, which in turn shapes structure, which shapes action, etc. Individuals may respond to interventions differently, as mechanisms are triggered by different contexts and shaped by the

environment in which they take place. However, most evaluations seek to test whole interventions, rather than develop programme theory[115]. Programme theory is important as it explores the process by which mechanisms intervene between the delivery of the intervention and the occurrence of outcomes of interest, mechanisms being enabling or disabling[4].

Pawson and Tilley illustrate the Context Mechanism Outcome configuration (CMOc) using the example of a gun[5]; when a spark (intervention) is introduced to gun powder, the change in the chemical composition of gun powder (mechanism) results in an explosion (outcome). However, there will be no explosion if the context is not right, for example, damp conditions, no oxygen present (context). Mechanisms are often referred to as a trigger. However, it is not correct to think of the above analogy as an 'on/off switch', as there are, for instance, varying degrees to which a person can feel (e.g. levels of confidence following participation in an intervention). Even when talking about stakeholder decisions whether to implement an intervention or not, engagement levels with the intervention may differ. Following the intervention, it is ultimately the decisions and actions taken by the 'human components' that generate the outcomes[113].

The realist perspective is not a method but a philosophy, so realist design can be incorporated within almost any impact evaluation. Such theory-driven approaches offer a more appropriate alternative to other approaches as they attempt to unpack the 'black box' - the 'ifs' and 'buts' in the chain of causation[113] between the intervention inputs and complex pattern of outcomes[118].

There are a number of approaches that can be taken to unpacking the 'black box'[113] of an intervention, and, whether qualitative or quantitative, each has its strengths and weaknesses. Realist research largely reflects the principles usually seen in qualitative research[113]. Although interventions cannot necessarily be replicated from one context to another and automatically achieve the same outcome, theory-based understanding about 'what works, for whom, in what contexts, and how', may be transferable and used to predict behaviours through theory development[105]. 'Answers' derived from data are explanatory and patterns allow for causal inferences to be made[113]. However, conclusions should be made tentatively when attempting to consider the implications on a larger scale or in contexts other than that in which the data originated. Pawson and Tilly[5] stated that the aim of realist evaluation is to produce generalisable findings from in-depth analysis of the themes

and patterns within contexts and mechanisms, transferability only being plausible through synthesising the data and drawing together data from differing contexts[108].

Quantitative data can explore outcome patterns and the relationship between causal variables, but cannot explain the underlying processes that generate the outcomes[4, 113]. It must be remembered that quantitative data is used to test theories about how and why a complex intervention works, the research design being iterative[108]. The views of Popper are of interest here. Popper stated that the main role of observations and experiments in science is to attempt to criticize and refute existing theories, rather than prove them[121]. Popper believed that we cannot prove that a theory is true, but we can show that a prediction is false. In taking this view, empirical research therefore cannot be used to prove that an intervention works, but can be used to test and refine the theory built into them. Popper advocated the introduction of small-scale interventions to check whether they were producing their intended effects and whether they were producing unwanted and unintended side effects. He promoted the use of trial and error learning to refine interventions. Popper believed this would produce both social benefits in the form of measurable reductions in particular social ills and would contribute to the development of social science[110]. Social policy and practice could benefit by testing out the effectiveness of interventions aimed at dealing with specific problems prior to their general application.

Combining the strengths of both qualitative and quantitative methodologies will help researchers to identify and triangulate rich evidence that will produce a coherent and plausible explanation of the contents of the 'black box'[113]. Exploring more than outcomes and contexts, but causation, is crucial for optimising development, implementation and effectiveness of interventions. Much of the success also relies on achieving immersion[113] i.e. spending enough time in the study to really know what is going on. The researcher must also collect data methodically and analyse them systematically, think reflexively, develop the theories iteratively as emerging data is analysed, look for alternative explanations and cases that may go against initial theory, and be able to defend their interpretations[113]. Dependability can be assured here through transparency and reliability, ensuring full documentation and that the research pathway is sufficiently illustrated. The realist approach also holds much credibility and conformability through respondent validation and ongoing discussions to check the theory (stakeholders, interviews etc.)[108].

However, the realist approach can be challenging as varying outcomes may occur and the mechanisms triggering these outcomes may be perceptions, which obviously cannot be seen

or measured directly. There are also likely to be multiple mechanisms that need to be expressed at an abstracted level so that they are not tied unnecessarily to particular contexts or populations[113].

2.6 Why was a realist approach appropriate for this current work?

This thesis not only sought to understand which interventions have the greatest positive impact on the transition of overseas doctors, but how and why the outcomes occurred. As evident in Chapter 1, supporting OMG transition is a complex problem. Difficulties are clearly operating at both individual and societal levels and so require a complex set of interventions to target all levels[105]. Interventions are therefore difficult to design. Interventions currently target both individuals (e.g. local buddying schemes) and wider populations of OMGs (e.g. regional inductions). Success of these will likely be dependent on both individual responses and the organisational context, particularly given the dynamic and diverse nature of the NHS. Because interventions differ in content, duration etc., it was felt that a systematic review would be too specific and inflexible. Realism allows for a certain amount of freedom to explore theory and illustrate the most vital components of the intervention needed to aid OMG transition.

Evaluation is currently lacking and interventions are often implemented without sufficient consideration of what is likely to work or how much training is appropriate[53]. This may be possible due to the complexity discussed above. The existing research on interventions for overseas doctors seemed to consist mainly of qualitative studies and 'grey literature' accounts (e.g. participant feedback, observations), that does not lend itself to statistical synthesis, but provides a rich source of qualitative data[113]. Interventions were also unlikely to lead to a single outcome. Hence a realist approach fits well when conducting the literature review. The realist approach is also seen as most appropriate for interventions that have previously demonstrated mixed patterns of outcomes, this too being found in the initial literature search. Many recommendations have been made, however the findings differed in terms of their focus. It also seemed that despite interventions that have been put in place throughout the years, the issues that OMGs were expected to face without the necessary support intervention were still apparent[32]. Therefore, it was of interest to find out why this was and how to improve current interventions. An example of where exploration is further needed was an intervention for those new to UK practice, implemented by Health Education England North East (HEENE). HEENE tried to arrange for a follow up to their induction for overseas doctors, however due to low participation, it had to be cancelled. There are many

questions that can be asked, for example, why did OMGs not want to attend? Did the first intervention work? If not, why? Was the training targeting needs? What other contextual factors may impact upon engagement? Realism provided the necessary ingredients for a high quality evaluation[110].

The Programme for Overseas Doctors (POD) evaluated in this thesis had only recently been piloted (see Chapter 1) and the intervention lead sought to understand whether the intervention 'actually works'. Realist evaluation was regarded as most appropriate for evaluating new initiatives or interventions that seem to work but do not explain how or for whom they are effective[104, 113]. The intervention running at Amity Hospital (AH) was also viewed as a complex intervention. It was made up of differing components, from communications skills to cultural awareness, and differing teaching methods, including role play and group discussions. The intervention also aimed to target differing transitional needs, such as increasing knowledge, increasing support, and increasing cultural awareness. Therefore, it was essential to understand which resources and contextual factors were impacting on which elements of transition. The intervention lead wanted to know which components were actually working, how, and why. Focusing on changes in behaviour for those who had undertaken the intervention versus those who had not would not have been useful. It was of interest to compare whether the intervention worked differently for different population groups and to consider other contextual factors. This is of particular interest given the complex needs and diversity of OMGs. Theoretical understanding of interventions intending to support OMG transition was lacking[53]. What motivates OMGs to engage with the intervention, and ultimately change their behaviour as a result, could not be studied empirically.

The intervention lead at AH further sought to provide guidance on developing and implementing POD to other North East Trusts, and potentially across the UK. However, groups of interventions cannot be deemed effective or ineffective, as their success is dependent on context. The realist approach is useful for understanding how to adapt the intervention to new contexts[104]. Theorising the unobservable was therefore necessary, as it was the only way to get to the deeper aspects of the reality of OMG transition. If only outcome data was collected, it would not be possible to identify the cause of the outcomes and therefore organisations would not be able to adapt the programme theory into other contexts. Realist approaches take this into consideration, assuming that a specific intervention will not work everywhere for everyone. Findings help to illustrate that there is

not a 'one size fits all' way of responding to OMG issues[122]. Through conducting a realist synthesis of the recent literature, it would allow for transferability of the findings, ensuring the focus was not only at AH. POD could instead be used to test and refine the middle-range theories developed through the synthesis.

Understanding which contextual factors may trigger the necessary change-inducing mechanisms, that are anticipated to lead to better transition, allows organisations to understand what aspects of the intervention make it effective, or ineffective, and what contextual factors will encourage consistently successful outcomes in other areas[110]. Policy makers at a national and regional level, as well as local Trusts, should be interested in the current research as it seeks to guide policy and make implementation easier (and more successful). Time and resources are more likely to be invested in developing and testing interventions guided by such programme theory.

2.7 Outline of realist methodology used within this PhD

The thesis adopted a realist evaluation informed by a realist synthesis[1] (illustrated in Figure 2). The process involved moving iteratively between theory and data, and between middle-range theory (developed through the synthesis) and programme theory (tested and refined in the evaluation).

- ***Phase one of realist synthesis*** - The first stage of this research, discussed in the next chapter, sought to identify and formalise a grand theory. Theories were built about how the intervention at AH was expected to work.

  Phase two of realist synthesis - Initial theories were used to guide a realist synthesis of interventions supporting OMG transition. These middle-range theories were tested using secondary data.

- ***Realist evaluation*** - The second stage of this research involved a realist evaluation of the Programme for Overseas Doctors (POD) at Amity Hospital (AH). The analyses aimed to test the proposed programme theory with primary data, explaining the observed outcomes and exploring how the intervention unfolded in practice. This then led to a refined programme theory.

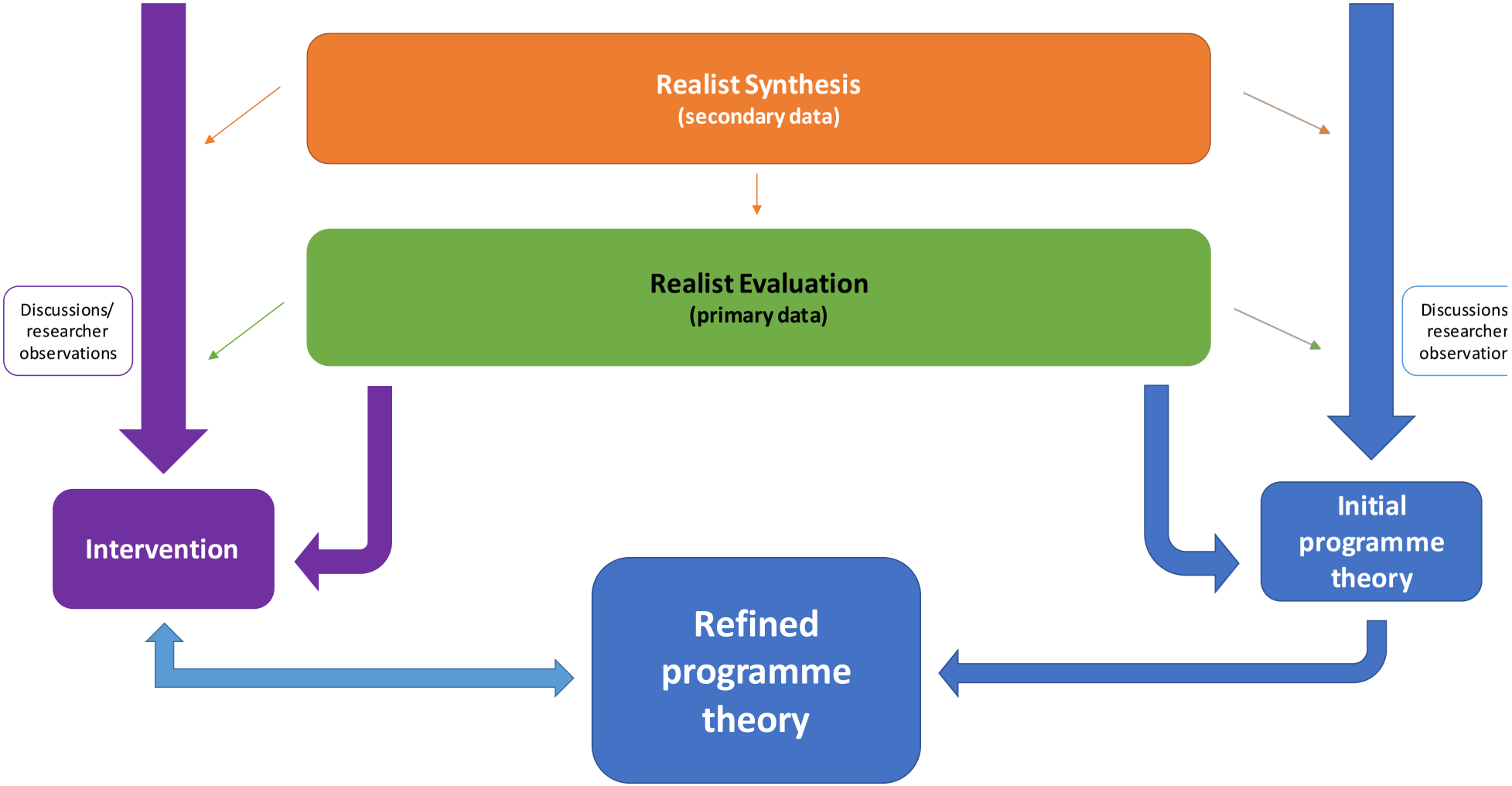


Figure 2. Overview of research project

2.8 Chapter summary

This section has reviewed the realist approach adopted in this thesis to evaluate interventions for OMGs, comparing it to key ontological and epistemological positions. The benefits and suitability of the realist approach for this PhD has been highlighted. Evaluation design that does not place context into consideration, seeking only to understand the 'pure' effect of the intervention, does not provide us with the knowledge as to how, when and for whom the intervention will be effective. These questions are precisely what this thesis seeks to explore.

Chapter 3 Phase one of realist synthesis - Developing middle-range theories

3.1 Outline

This chapter discusses the first phase of the realist synthesis, which involved the development of overarching middle-range theories to explain the active mechanisms and contexts of interventions supporting the transition of Overseas Medical Graduates (OMGs). The aims and methods of this phase are presented. The process of theory development is then described in detail, which included the identification of case studies, discussions with key stakeholders, and exploration of relevant learning theories (grand theories) and OMG literature. The developed theory was then used to conduct the realist synthesis, presented in the next chapter.

3.2 Theory development – Phase one aims

A realist synthesis was conducted in this PhD to develop an integrated and broader theory explaining how interventions support the transition of OMGs to the workplace, ultimately helping to answer some of the research questions set out in Chapter 1 (also presented in Chapter 4). It was essential to explore how OMGs are likely to learn and the particular context and mechanisms that may enable or hinder this. The aim was to review the literature so that theories could be identified and developed from the data. By identifying theories that emerged from the data (middle-range theories), there was the potential to significantly increase efficiency of both intervention development and evaluation[123].

3.3 Theory development – Phase one methods

Realist approaches begin by eliciting and formalising an overarching theory as to how the set of interventions included in the synthesis, or evaluation, may work[5, 124] and describing how contexts and mechanisms lead to the desired outcome. Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) quality standards were used to guide the method[124].

Initial theory formulation was achieved through searching relevant OMG literature, policy documents, face to face discussions with stakeholders from a number of organisations (including funders, clinical educators, clinical directors, supervisors, intervention leads, individuals from the GMC and HEENE, trainers, and academics in the field), and discussions within my supervisory team (who were familiar with both OMG and transition literature).

These were later developed through observations of POD, analysis of the literature, and application of relevant grand theories (see section 3.5). It was necessary to move iteratively between all data to test emerging middle-range theories[113].

Theories specific to cultural adjustment were explored[3], these perhaps explaining why some OMGs are able to learn, and ultimately adjust, better than others. How OMGs transfer learning to their practice was also important to consider. Learning theories (grand theories) that may be applicable were therefore explored (the purpose of these grand theories was to feed into the development of middle-range theories specific to this project, rather than seeking to prove them correct).

A brief overview of the realist synthesis (including both phase one and two) is presented in Figure 3. Detailed exploration of the methods used in phase two of the realist synthesis (literature search onwards) are presented in Chapter 4.

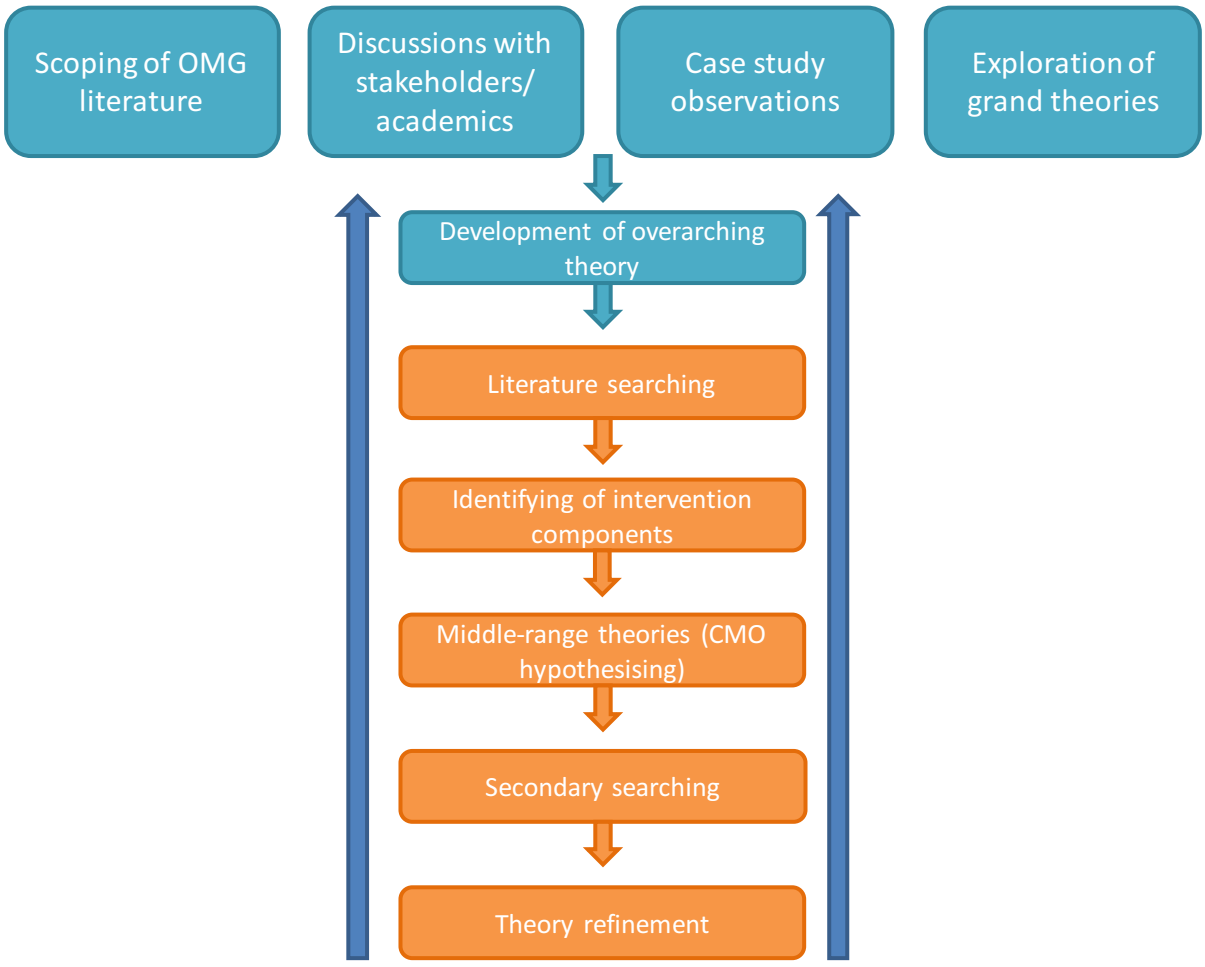


Figure 3. Overview of realist synthesis within this project (blue boxes indicate phase 1 and orange boxes indicate phase 2)

The use of realist methodology here was novel, in that the synthesis was conducted in parallel to the implementation and evaluation of POD (each informed the other). Theory fed into the development of Programme for Overseas Doctors (POD) throughout the whole process, including the middle-range theories presented in this chapter.

It is important to note that repetition of theory throughout the thesis is inevitable due to the realist approach adopted; the primary purpose being theory development and refinement. This is evident in Chapters 3, 4, 7 and 8. It was essential that potential theories were tested on a number of occasions. The nature of the realist approach also meant similar methodologies were used during each phase of the research. Repetition of description has been reduced as much as possible.

3.4 Case study - Programme for Overseas Doctors

As mentioned in earlier chapters, POD at Amity Hospital (AH) was at the centre of this research and therefore the focus of the evaluation presented in later chapters. Observation of the intervention provided an opportunity to test the developing theory (observation of the full training programme took place in May 2014 and July 2014). Discussions were initiated with key stakeholders and all of those involved, including the OMGs that attended.

The intervention was primarily targeted at those doctors new to UK practice, however OMGs that were already working in the hospital, but were identified as facing difficulty, were invited. As with the pilot interventions, external language tutors from Refugee and Asylum Seekers Centre for Healthcare Professionals Education (REACHE) were recruited to deliver communication skills training. REACHE is a hospital based unit that provides education, training and support for internationally trained refugee and asylum seeking health professionals who are seeking work in the UK[125].

3.5 Learning theories

Early intervention can reduce the time OMGs spend navigating through the system. Successful strategies allow them to devote more time to patient care and overcome issues with performance or patient safety[96]. As discussed in Chapter 1, the barriers that OMGs may face in their transition are known[29]. The issue is how to implement effective interventions that will optimise their learning. Exploration of relevant learning theory was crucial in understanding interventions and developing initial theory.

Learning involves synthesising different types of information; including the individual's cognitive, emotional and environmental influences, as well as experience, when developing

(or modifying) knowledge, skills, behaviours, or values[126]. Learning theories help us to understand how information is absorbed, processed, and retained during learning experiences[127]. There are many grand theories that could be applied to OMG learning, however, key theories that were relevant to the implementation of interventions for OMGs are described below.

3.5.1 Social Learning Theory

Many theories applied to work-based learning are rooted in, or at least have elements of, Social Learning Theory. Bandura's Social Learning Theory[128] focuses on learning that occurs within a social context, showing that people learn through observing others and by attending to the consequences of their own actions. The theory includes ideas about observational learning, imitation, and role-modelling. Although Bandura believed that reinforcement aids learning, he contended that people can learn in the absence of reinforcement and even of a response. All behaviour is followed by some form of consequence, but whether that reinforces behaviour depends on the individual's cognitive evaluation of the situation.

One of the core elements advocated is the concept of self-efficacy. Self-efficacy is an individual's belief or confidence in their ability to succeed in producing a particular outcome[128]. Research has highlighted the influential role of perceived self-efficacy in human self-development, adaptation, and change[129]. Perceived self-efficacy can have complex effects on motivation, thought, affect, and action[128]. Self-motivation is influenced by a person's efficacy expectations; motivation being needed for individuals to both engage with and transfer learning. When self-efficacy is strong, individuals will tend to get more involved in activities and put more effort into completing tasks[128]. During discussions with OMGs at AH, increased self-efficacy following POD was noted.

Learners build self-efficacy through four principle sources; performance accomplishments, verbal persuasion, vicarious experience and physiological states[128]. Performance accomplishment is dependent on individual needs and the context in which new knowledge is acquired, which should aim to boost knowledge and sense of achievement. Self-efficacy is likely to increase through feedback and opportunity for self-directed learning, helping individuals to take ownership of their learning. Supervisor feedback and self-reflection are therefore essential for OMGs, particularly if they have low confidence or are facing challenges in adjusting to the workplace.

Verbal persuasion may be the verbal encouragement from educators, supervisors or peers. A feeling of acceptance and becoming part of a team is also likely to be critical for OMGs to adjust to the workplace. Support from and discussions with these key figures will likely to lead to increased engagement with learning activities.

Vicarious learning is the observation and interaction with others, creating new knowledge from experience[128]. Interventions should encourage group performance and communication, particularly the sharing of experiences. This is of importance when inducting OMGs into the NHS, given the likelihood that they will have different practice and cultural experiences. Observational learning is more than simple imitation. The core concept of modelling involves adding and subtracting from observed behaviours. Bandura recognised four steps to observational learning; firstly, attention (noticing what the role-model does), representation (new response patterns are put into memory), behaviour reproduction (of behaviour observed) and motivation (observer must be motivated to perform the observed behaviour). Individuals are also more likely to model individuals with high-status. Those who lack status are most likely to seek role-models with status. Applied to OMG transition, OMGs are likely to feel that they have low status in a new country and new place of practice. They may be more likely to model OMGs who they perceive to have high status, such as consultants, in comparison to those in lower positions. This would most likely be the case for those who are from a culture where importance is placed on status[56]. Individuals also tend to model behaviour that they see as being rewarded.

Finally, physiological state refers to the fact that emotional state can influence the level of perceived personal competence[128]. OMGs may face issues due to avoidance behaviour, in which they may avoid anticipated unpleasant situations. Emotional arousal is likely to be high during OMG transition due to increased anxieties and fears. Interventions should aim to help OMGs to diminish emotional arousal as this can reduce avoidance behaviour. Bolstering self-efficacy can also help to reinforce engagement in modelling new cultural behaviours that have been learnt through the intervention, which may then be transferred to real clinical settings. Use of simulation training and role plays, such as those in POD, can aid in this and in preparing OMGs for practice.

Outcome expectations (beliefs about consequences) and goals (beliefs about achievements) are also crucial in this theory. Perceived contextual supports and barriers are thought to affect the ability to pursue and achieve goals.

Social Learning Theory addresses how attitudes are formed and accounts for the influence of peers and the institutional culture of organisations. People experience unease when they perceive conflicting attitudes in themselves. Such 'cognitive dissonance' is a known driver of attitudinal change[130]. However, Social Learning Theory does not address what the learner does following the formation of attitudes (e.g. is reinforcement necessary for both learning and performance?). It also fails to consider the role of individual differences in the uptake of new behaviours, particularly motivation and emotion.

3.5.2 Social Identity Theory

Social Identity Theory asserts that individuals exist in a social world in which they have to construct their identities in relation to the environment[131]. It proposed that groups to which people belong are an important source of self-esteem. Groups give a sense of social identity and a sense of belonging[132]. A learner therefore can be strengthened and enriched by the environment around them, ultimately impacting upon their development.

In reference to providing an intervention for OMGs, there may be a sense of stigma around being labelled from 'overseas'. Social Identity Theory states that we define appropriate behaviour by reference to the norms of the groups that we belong to. If there is a sense of 'us' and 'them', adjustment is unlikely to take place. It is critical that OMGs feel they belong to the organisation so that they are motivated to adopt the beliefs, values and norms of those around them. Once adopted, this will help individuals to perceive and react to organisational situations from this group-based perspective[133].

Conversely, it is likely to be beneficial for OMGs to identify with those facing similar issues and going through the same transition process, OMGs being able to support one another during interventions and ultimately afterwards. This may lead to increased engagement, motivation to learn and self-esteem. However, if self-esteem is to be maintained, the group has to compare favourably to UK graduates[133].

Most learning theories fail to pay attention to the identity-based dynamics of the group[133], which is likely to be a key input to or driver of learning and performance of OMGs in the workplace. However, Social Identity Theory is only one lens through which OMGs may view their work and the organisation.

3.5.3 Experiential Learning Theory

Kolb provides one of the most useful models of the adult learning process, acknowledging the role of the learner, learning through practical experience, and reflecting on the

process[134]. This was identified as key in initial discussions about POD; OMGs felt that they learnt more by practicing and reflecting on their performance. Through this hands-on experience of an activity or skill, a learner can incorporate conscious and unconscious learning mechanisms, leading to a deeper processing[135], that will result in similar activity/behaviour in the future. It is suggested that there are four stages in learning[134]; concrete experience, reflection of that experience (personal level), abstract conceptualisation (development of general rules describing the experience) and active experimentation (construction of ways to modify future experiences). These are then tested at the next concrete experience. Different learning styles were also built around this cycle[136]. Individual learning styles need to be taken into consideration, particularly in the case of OMGs where cultural practice and learning can be very different to that in the UK[56].

One facet of experiential learning is situated learning, which illustrates that learning is unintentional and situated within the same authentic context in which it is applied[137]. Knowledge is ultimately developed through the process of adjusting to the context. In asking what kinds of social engagements provide the proper context for learning to take place, this can aid in the development of interventions.

Problem based learning is another example of experiential learning, or active learning. Individuals learning. In this approach, individuals learn through the experience of solving an open-ended problem[138]. Through this experience, both thinking strategies and knowledge can be developed. The goals of problem based learning are to help individuals to develop flexible knowledge, problem solving skills, critical thinking, collaboration skills, self-directed learning and inherent motivation. Problem based learning helps to engage the learners and highlight the relevance and importance of the learning to practice.

Although learner experience is crucial to learning, the notion of learner 'feeling' is not defined or elaborated on in Experiential Learning Theory[139]. The model also focuses on the learning process for a single learner and fails to recognise the role of the social group.

3.5.4 Transformative Learning Theory

The teaching of knowledge and skills is straightforward compared with the problem of 'teaching' attitudes, which are embedded in personality and influenced by family, community and culture[140]. Although the resulting diversity is to be celebrated, it also creates a challenge for the educationalist. This theory offers a potential structure for the understanding of attitudinal learning.

Transformative learning asserts that learning involves individuals having what they know and believe directly challenged; resulting in a reflective learning process (both personally and communally). For learners to change their meaning schemes, i.e. attitudes, beliefs and emotional reactions, they must engage in critical reflection on their experiences. This will lead to perspective transformation (new ways of defining their world)[141]. Individuals must then consciously make and implement plans. The meaning schemes that make up meaning structures may change as ideas are added and integrated to their current scheme, occurring through learning. Learning is dependent on the individual and how they interpret, validate, and reformulate the meaning of their experience. Trainers therefore have to provide opportunities for learners to assess, and be critical of, their beliefs, feelings and values, and assist them in becoming more aware and critical of assumptions. Educators, and peers, also act as role-models by demonstrating a willingness to learn and change. Methods such as role plays, simulation, case studies and group learning have been used with OMGs to improve their understanding and develop well-informed judgments. These methods aid in transformative learning by causing individuals to re-examine their beliefs in the context of medical practice and analyse the justification of their acquired new knowledge; about themselves, others, and social norms.

Transformative learning is often the result of major life crisis or transition (a disorientating dilemma)[141]. Hence, this theory could inform the development and understanding of interventions for OMGs (who face a major transition). Establishing an environment that builds trust and facilitates the development of relationships amongst peers, allowing for the sharing of experiences and critical reflection of others assumptions, is a fundamental principle of fostering transformative learning[141]. Peer support and collaboration has been highlighted as crucial for OMGs (see Chapter 1). OMGs may feel a sense of alienation and therefore being able to relate this to others and understand options of new behaviour is likely to lead to transformative learning; building their confidence and allowing integration into new roles.

Whilst this theory has been criticised for placing too much emphasis on rational critical reflection[142], it does sit well in terms of OMG transition, in which reflection and change in attitudes is critical. The theory not only incorporates many elements of the learning theories previously discussed in this chapter, but also has more focus on the transfer of learning. If OMGs are to transfer what they have learnt into practice, it is important that they do not just learn about practical application, but change their attitudes and perceptions. Cultural

differences will become apparent in this process, having to understand and reflect on their identity rather than just simply do what is seen as the norm.

3.5.5 Transfer of Learning Model

Transfer, in terms of training and development, is the effective and continuing application of material learned though training (e.g. knowledge, skills) to the job context, as well as the maintenance of the learned material over time in and outside of the job[143]. Similar to transformative learning theory, the Transfer of Learning model focuses on how past experiences affect learning and performance in a new situation.

Bransford *et al*[144] identified four key characteristics of learning in terms of transfer; the necessity of initial learning (simple exposure or remembering is not learning, there must be understanding), the importance of abstract and contextual knowledge (level of abstraction of knowledge that goes beyond the context in which it was learnt), learning as an active and dynamic process (engaging in activities that extend beyond current abilities), and the idea that all learning is transferred (new learning builds on previous learning). Transfer occurs at a subconscious level if the learner has achieved automaticity of the relevant knowledge or skills to be transferred. Differences in the problem-solving context will also be handled at a subconscious level, but most likely with some conscious thought. Emphasising how to apply the new knowledge and increase motivation should improve transfer. Learners should also be encouraged to make their thinking evident. Recognising different cultural behaviours in practice and addressing misconceptions would be vital for OMGs.

There are a range of viewpoints and proposed theories within the literature as to how the transfer of learning occurs and how this relates to learning in general, research identifying many factors affecting the transfer of learning back into the workplace[145]. The Transfer of Training model[143] was identified as being the most appropriate grand theory in explaining OMG learning and transfer to practice. Justification for this is presented in section 3.5.6.1.

3.5.6 Transfer of Training

Baldwin and Ford proposed a simple model that suggested the transfer of learning depends on training inputs that included trainee characteristics, training design and work environment (see Figure 4)[143]. The outcome of training is impacted by trainee characteristics and work environment in a direct manner. The impact of training design depends on the levels of training outputs (learning and retention). The model enables evaluators to assess the impact of each individual input factor in training and hopefully improve the different

elements of each of these factors, particularly looking at how learners' motivation to transfer is related to later job performance. It suggests OMG transition will only take place if individuals learn, apply, and then maintain what they have learnt.

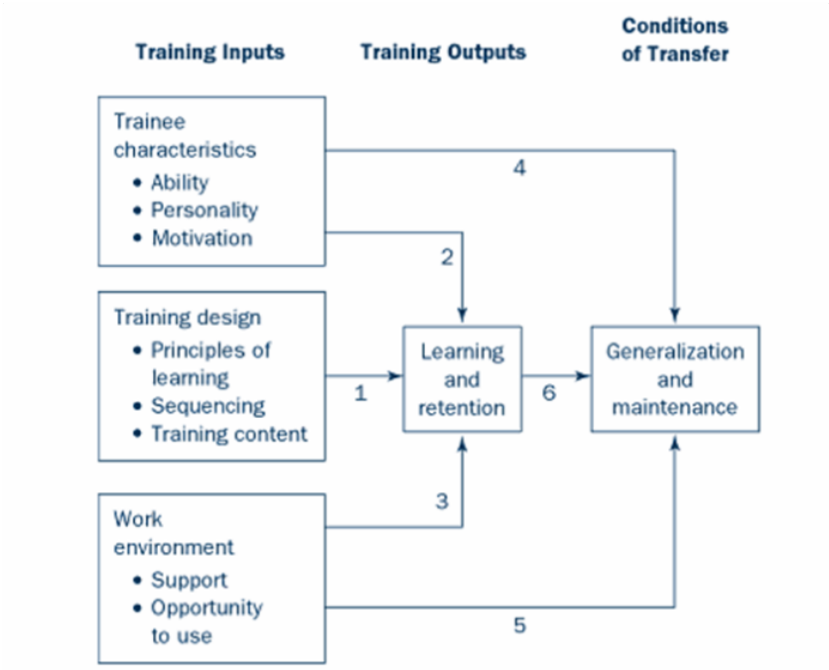


Figure 4. Factors affecting transfer of training[143]. Numbers 1, 2 and 3 illustrate the impact of the three training inputs on learning and retention, whilst numbers 4, 5 and 6 illustrate the impact of the three factors on generalisation and maintenance (with learning and retention being central to this)

3.5.6.1 Justification for using the Transfer of Training model

Whilst all the theories discussed in this chapter are pertinent and useful in understanding different aspects of OMG learning, they are limited and do not fully explore the transfer of learning back to practice. No other theory presented encompasses all elements of OMG learning and transition in a single model. The Transfer of Training model incorporates most of the critical features (proposed mechanisms) of the learning theories discussed in this chapter, such as the role of self-efficacy, motivation, identity etc. Additionally, interventions developed for OMGs are often complex, therefore application of a specific learning theory would not be useful. The Transfer of Training model therefore enables a better understanding of how interventions can help OMG adjustment to working within the NHS.

The three levels proposed in the Transfer of Training theory are most applicable to OMG transition and relevant to the research aims. The levels help to both understand and analyse the influence of environmental, training and individual characteristics. Individual characteristics will inevitably play a major part in OMG learning and ultimately transition (e.g.

culture, prior experience and motivation), whilst the level of training and support from the workplace are important, both during the intervention and when applying training to practice. Ultimately, the applied nature of the model aids in understanding the contextual factors that are at work when transferring learning into practice, as well as highlighting potential mechanisms.

Kirwin and Birchall's model of learning transfer[145], an application of Baldwin & Ford's model[143], also informed the initial middle-range theories. As figure 5 shows, the model places emphasis on individual motivation and ability to transfer. Their model clearly indicates many of the elements that have become apparent as being crucial to OMG transition (e.g. support, learner readiness, individual capacity, opportunity to use, self-efficacy, feedback etc.). Baldwin and Ford's model was a useful starting point, however unlike the model proposed by Kirwan and Birchall, it lacked detail and did not explore key interactions between (and within) the three levels. The application of Kirwan and Birchall's model to initial middle-range theories is discussed later in the chapter.

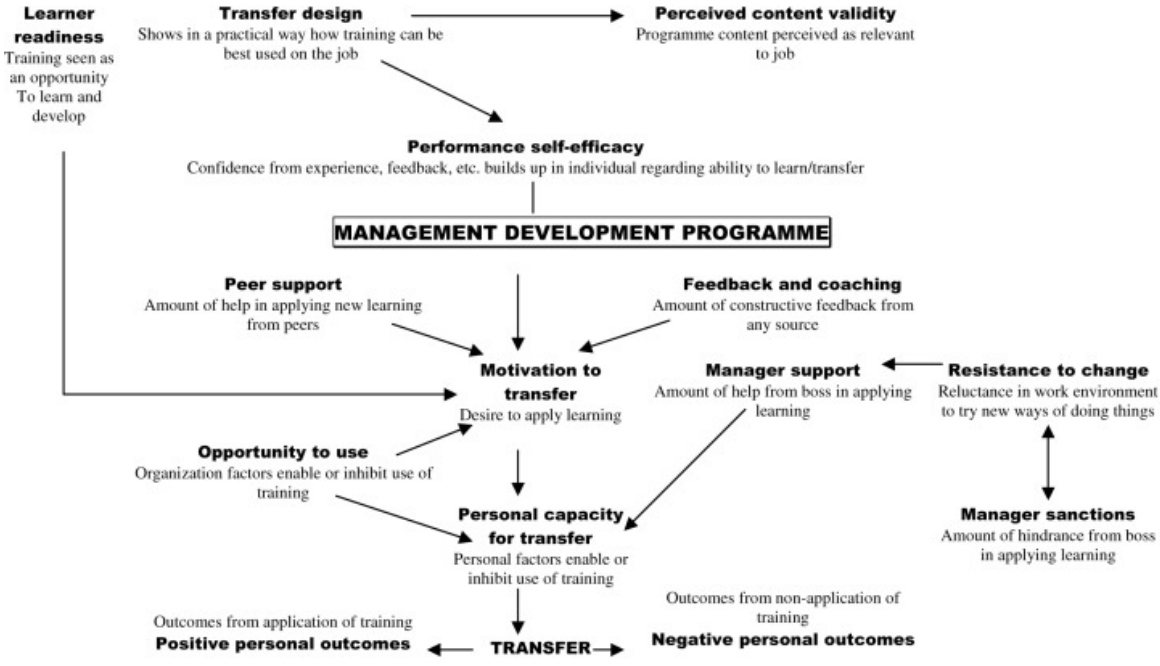


Figure 5. Model of learning transfer applied in a management development intervention[145]

3.6 Phase one findings - Initial middle-range theories

The proposed theoretical concepts will now be discussed, drawing on initial discussions and observations, the theories described above, and evidence from the OMG literature (Chapter 1). Outcomes will firstly be discussed in section 3.6.1, followed by an exploration of factors at three levels identified as being critical for interventions to successfully support OMG transition (illustrated in Figures 6a, 6b and 6c).

3.6.1 Defining transitional outcomes for OMGs

We need to firstly understanding the aims of interventions for OMGs before considering them in the context of the Transfer of Training/learning models (developed middle-range theories). Therefore, outcomes are discussed first, illustrating what is meant by a successful transition. It was crucial that outcomes were made explicit so that appropriate context and mechanisms could be identified.

Adjustment theories are suggested in the literature, exploring the process of loss, disorientation and adaption, and the occurrence of either culture shock or acceptance of cultures[68, 79, 146]. These theories help to understand the transition process. Culture shock is crucial to adjustment[147]. Following the initial lack of awareness of differences, and then highs of moving to a new country, differences may become more salient. Frustration caused by difficulties communicating and performing basic tasks may increase[147]. Frustration may then lead to irritability, depression, and other symptoms of culture shock[147]. These factors, as well as increased anxiety and feeling like an outsider, may cause individuals to leave. OMGs may also be tempted to cling to their own culture by associating with those of a similar culture; but this can extend and intensify the crisis phase of culture shock. The recovery phase following culture shock, comprises of a gradual adjustment to the new environment, likely including a regain in self-esteem, optimism and motivation to become part of the new culture[147]. Eventually, individuals will have the ability to function in the new culture and ultimately feel a part of it, whilst also maintaining their cultural identity. Individuals may also move back and forth between the stages. Although important factors are presented in these adjustment theories, transitional outcomes are not fully explored.

Middle-range theory outcomes in this project were therefore based on Harrison and Shaffer's Adjustment – Effort – Performance Model[3], categorising the differing areas of transition for OMGs. Their model is based on general principles of motivation, being defined as a process that is triggered by a deficiency or need. Like the Transfer of Learning model, it too looks at individual and organisational factors that influence job performance. It proposes

that when adjusted, individuals will direct more of their personal time and energy resources into behaviours that will facilitate their job performance. The model highlights three elements of transition; cultural adjustment, work adjustment and interaction adjustment. Although the adjustments suggested by Harrison and Shaffer are described as psychological adjustments and do not take contextual factors into consideration, they do suggest that these areas predict job performance and retention. These have therefore been adapted to fit the overarching theory of this research.

Cultural adjustment refers to the comfort associated with various non-work factors such as general living conditions, local food, and transportation. Within this research, cultural adjustment also refers to acculturation to the workplace and links made to the cultural adjustment theories highlighted above. Work adjustment refers to comfort with the assigned job or tasks. Performance and retention are example indicators of work adjustment. Interaction adjustment refers to the comfort associated with interaction with host country nationals both inside and outside work. These three areas, along with general adjustment (such as practical issues e.g. visas), are evident in research looking specifically into healthcare transition[59].

Work adjustment, which does link to both interaction and cultural adjustment, unsurprisingly seems to be the focus of most OMG interventions. Work adjustment is the process of achieving and maintaining this correspondence[148]. Adjustment will occur if the environment and the individual continue to meet each other's requirements for the interaction to be maintained (correspondence)[148]. This links to the Transfer of Training model, highlighting the importance of individual and work environment factors. The more closely a person's abilities (skills, knowledge, experience, attitude, behaviours, etc.) correspond with the requirements of the role or the organisation, the more likely it is that they will perform the job well and be perceived as satisfactory by the employer. Similarly, if the work environment corresponds to the values that a person seeks to satisfy through their work, the more likely it is that the person will perceive the job as satisfying. This is seen to predict the likelihood that someone will stay in a job, be successful at it and progress in their career[148].

The flexibility of a person or an environment will also determine the extent to which they can tolerate a mismatch between their abilities and what is required of them, or differing values. Internal factors (such as personality or organisational culture) and external factors (such as the availability of alternative options) will influence the level of flexibility[149]. When the lack of correspondence is too great, some form of adjustment often takes place. For

example, active adjustment by the individual involves them trying to change their working environment. Reactive adjustment may involve the individual trying to change their behaviours to better suit the environment or by changing their personal priorities or work values. The environment can help to facilitate this adjustment, for example, considering previous experiences and natural strengths that they can bring to the job role. When no further adjustment is possible, the person may leave the job or they may be fired.

As is illustrated, the proposed outcomes are concerned with more than just knowledge or skills, but deal with attitude change that is needed to ensure OMGs transition to the new workplace and culture. Although it may appear difficult to determine how learning outcomes are translated into performance improvement and overall adjustment[145], this is something that the realist approach can help to overcome. The use of CMOcs can help to explain the process (see Chapter 2).

3.6.2 Work environment (organisational level)

Culture/climate:

There is a great amount of significance placed on work environment factors in the Transfer of Training models[143, 145]. The most important factors concern the creation of a supportive culture encouraging the transfer of learning. This climate will then aid in the individual's engagement with training, and motivation and ability to transfer their learning. The GMC highlight this: 'The evidence is overwhelming and yet the message is still not being heard: in addition to technical expertise, the way we behave towards each other, how we function in teams, how we lead and are led has a significant impact on patient experience and patient outcomes!'[150]. It is suggested that support will impact on the level of effort individuals put into their job, especially important due to the current shortage of staff. In simple terms, if management is nicer to their staff, staff will be 'nicer to patients'[150].

Organisations must ensure that the culture within their Trust allows for OMG transition into the workplace, creating an environment that fosters their learning and promotes questioning if unsure (interaction adjustment). If OMGs feel isolated from UK graduates they are unlikely to have the confidence to question, particularly if they have had previous negative experiences of doing so. This is then likely to lead to further anxiety and stress, both inside and outside of work. Many things can affect the distress felt by staff, regardless of where they graduated, such as workload and work-life balance, but OMGs are likely to be facing even more difficulties[2].

Acculturative stress is the reflection of difficulties in adjustment to a new culture, new work settings, healthcare system, patterns of work and often a new language[51]. This is something organisations must be aware of and address. If stress occurs early in adjustment, OMGs may not be inclined to engage in interventions offered. This initial lack of organisational support, may lead to early negative experiences and ultimately impact on engagement and motivation to transfer later in practice. If OMGs do not hold the necessary knowledge or skills about their practice, as well as feeling unsupported, confidence in both themselves and the organisation will decrease[126].

The geographical location in which OMGs are working is also important and should be highlighted to the individual before arriving. Issues are likely to arise in rural communities[151], where satisfaction may be low due to an inability to access religious facilities and cultural or religious goods. Access to cultural communities can create a greater level of satisfaction for OMGs and their families. The needs of OMGs must be addressed and should begin with the selection process/recruitment stage, which should match the candidate's needs, family needs and characteristics of the community.

Leadership:

Engagement in the support process relies on 'manager support'. Strong leadership and an enthusiastic driving force must be behind the interventions, recognising the need for OMG support and making others within the organisation aware of this (this has been highlighted in discussions with those involved in POD, and other key figures). OMG needs must be made evident to all colleagues and staff to ensure they are receptive and aware of possible difficulties that may be faced. Overcoming resistance to change and increasing motivation for OMGs to transfer is essential[145].

Resources:

Resources must also be available to ensure OMGs engage with appropriate and effective training. However, pre-migration, migration and post migration experiences are all likely to be affected by time available[51]. One area largely ignored by interventions is the pre-migration stage. Although some resources are available, most organisations fail to make OMGs aware of these before they arrive e.g. OMGs did not know about an NHS information pack that has been available since July 2014. This highlights how resources have been created but not utilised by OMGs. If OMGs are well informed prior to arrival then they are more likely to have an increased awareness of what is expected of them. This will likely reduce initial anxiety and

stress. It may also prevent issues arising and reduce the amount of support required at a later date.

Organisational support through its culture and leadership, as well as offering resources, was noted during discussions with those who attended POD. OMGs felt grateful to the organisation and more confident in practicing within the workplace.

3.6.3 Training design (training level)

Learning preferences and needs assessment:

Careful consideration of training design must be taken before implementing interventions for OMGs, who have often been exposed to differing learning approaches[74, 152]. Understanding about UK practice will be influenced by cultural, as well as clinical, aspects.

Employers should understand the individual needs of their OMGs in order to support them[153], acknowledging previous experiences, culture, values, attitudes, expectations, and knowledge etc. Hofstede's cultural model[56] presented in Chapter 1 highlights the cultural dimensions that organisations should be aware of in OMG transition[57]. OMGs often have good theoretical knowledge, which may be due to a didactic approach to teaching in their own countries. However, cultural differences will likely impact upon adjustment to the UK system; the open, friendly approach advocated with patients in the UK being very different to some overseas practice (such as high power dissonance or high uncertainty avoidance cultures)[56]. Some OMGs may be used to a family orientated approach to delivering information e.g. the diagnosis, the patient often being told last or not at all by the doctor. Rapport building is uncommon in a lot of other cultures.

Where power distance was high or there was a sense of guilt and shame in their culture, OMGs may face challenges in disclosing error[154]. A more hierarchical structure may have also meant that the student-teacher relationship has been more rigid and therefore some OMGs had not been used to questioning when they faced uncertainty. In the UK, junior doctors are expected to approach their seniors. Those used to individual learning through textbooks will be less used to receiving feedback. OMGs from such cultures may also find the concept of reflection and professional development difficult to grasp, being used to prescriptive learning[56]. Levels of individualism may impact upon OMGs expression of opinions, which may be perceived by UK colleagues as lower confidence levels. This reticence may also reflect a more feminine society, where there is less emphasis on competition. Those from countries with high masculinity are likely to be highly motivated[56].

Some OMGs may also lack awareness around working in multidisciplinary teams, which can create challenges for OMGs when communicating[75, 155] (impacting on work and interaction adjustment). Nurses may not be regarded as true colleagues in some countries[47], in contrast to the UK where they are seen as an integral part of the team, involved in decision making and approached for advice[58].

Interventions must take into account that doctors in different stages of transition will face different problems and different training needs[3, 97]. Many OMGs have also had long career gaps[59], which can cause a lack of self-efficacy (confidence) and impact upon their learning abilities. The content of the training must match individual needs[156] and be perceived as relevant, otherwise they will not be motivated to learn[145]. If value is seen, individuals will want to apply it in practice.

Design/implementation:

The use of effective teaching methods should be considered when designing training programmes for OMGs[157]. 'Having a supportive environment and learning from practice are important for international medical graduates adapting to practice' is argued by Maudsley[158], highlighting the importance of experiential learning. Role plays and simulation are one of the best ways to focus on further development of what has been learnt[157], aiding in problem solving across differing contexts and ultimately leading to the transfer of learning. Repeated exposure is important to ensure comprehension. The importance of vicarious learning (observing others) and role-modelling[128] is also essential in OMG learning, the supportive environment being an opportunity to learn from observing peers in the same situation. OMGs' self-efficacy is likely to increase from listening to those who have perhaps been through a similar transitional experience and had a successful outcome.

As the theories presented earlier suggest, transformative learning must take place if OMGs are to change their attitudes and transfer learning into practice. A question raised in discussions was whether OMGs actually change their values/beliefs or whether they are merely acting in a socially acceptable way during the intervention. This is important because they may revert back to their initial behaviours when they are not observed. Observers can learn, albeit passively, through role-modelling or through direct patient contact on the wards and in clinics. However, these methods do not require learners to directly uncover or challenge their attitudes, which might require modification and unless tested, might not be challenged[140]. It may therefore prove better for individuals to practice and make mistakes prior to interventions, rather than merely practice what has been learnt. Through problem

solving or situated practice (as discussed previously), deeper processing may take place and they will be less likely to revert back to previous behaviours[138]. Individuals should be given the opportunity to react to a scenario using their own experiences, and if wrong, they can be corrected.

Feedback and reflective practice is necessary for learning and ultimately the transfer of learning, but whether feedback is sought to boost ego or to learn is not always clear[157]. Using systematic feedback and reinforced practice are empirically grounded principles of learning that have been found to improve communication skills with OMGs[125]. Emphasis should be on feedback opportunities to maximise gains in self-efficacy, increase participants' awareness of outcome expectancies and increase understanding of the impact of new behaviours[159]. Reflective practice is needed for OMGs to reflect on their experience and establishing new norms. 'What' an individual is doing right is not as important as 'why' they are doing it right.

Support network:

Social support, also referred to as social networks, is found to be an effective stress buffer, providing OMGs with access to a variety of resources and creating pathways through which resources can flow[160]. Support is needed to aid in navigation to the new system and culture. It has been found that those who have higher emotional support are more likely to have increased mental health[51], which can assist in cultural adaption and eventual integration.

Cultural Health Capital can be described as a 'coherent collection of cognitive, behavioural, social and cultural resources' (p.3)[161] which aid in optimising relationships between the health professional and patient or colleagues. Cultural Health Capital can be formal (educational/professional) and informal (affiliation to ethnic communities, social and professional networks, values, motivation, coping strategies). General adjustment is likely to be addressed here. Hatzidimitriadou *et al* [12] found that those who do not use their Cultural Health Capital effectively were the most vulnerable in terms of professional development and psychosocial wellbeing. OMGs do actively use resources related to Cultural Health Capital, therefore it is essential the necessary resources are available. Cultural Health Capital includes the acquisition of cultural skills, health literacy, verbal and nonverbal competencies, attitudes and behaviours, an orientation towards future careers and adaption of interaction styles[161], therefore leading to increased self-efficacy and a sense of mastery, increased motivation and engagement, and an increase in professional development. Such

educational, intellectual and social resources can be acquired over time, however socialisation can aid in this[162].

Resilience also plays a big part in this, social networks being thought to have an effect on both resilience and behaviour[163]. OMGs need to be resilient in order to be able to face any challenges or setbacks in their transition; therefore, learning environments should nurture self-efficacy, encourage optimism, promote concepts of personal health and advocate reflective practice. Social networks play a critical role in the provision of support for those at risk of hardship, helping them to overcome obstacles and ultimately helping them to apply the skills that they have learnt[159]. Relationships are also critical in developing a sense of belonging[160]; which has also been linked to performance and retention.

There must, however, be a balance between bonding social networks (with those from the same culture) and bridging social networks (with those from a different culture) social networks. These both promote resilience through emotional support and receiving ideas through alternative pathways about how desired goals can be achieved.

'Social capital' refers to the connections among members, and it includes three facets: the structural dimension (social interaction), the relational dimension (trust) and the cognitive dimension (shared vision)' (p.180)[164]. Social capital is ultimately a set of resources that exist in relationships, and is both a cause and effect of engaging in social groups. 'Bonding' social capital refers to the connections within a close social group of like-minded people (such as same ethnicity or group) which provides support and reinforcement of identity. OMG groups attending interventions can bond through sharing experiences and learning from each other's stories. Bonding social capital, intracultural communication and networks allow OMGs to access their prior knowledge, experiences, and sometimes language; which is important in adjustment in allowing an individual to maintain their professional and personal identity. 'Bridging' social capital refers to the development of connections and resources developed with individuals who are members of other social groups or from differing cultural backgrounds. Bridging networks are diverse and connect people who may experience different views of the world. Increasing bridging social capital, intercultural communication and networks provide access to the wider community and have been demonstrated to play a key role in cross-cultural adaptation and ultimately acculturation[151]. In terms of workplace relationships, improved intercultural communication and networks creates opportunities to have social interaction with a greater number of others within the workplace and wider community. Such a relationship allows individuals to access resources that are unavailable

within their close network. Lack of bridging social capital in the form of relationships with senior colleagues or more successful peers can also limit essential networks and resources. It is anticipated those with greater bridging social capital may exhibit great propensity to remain in post[160].

Chang *et al*[164] further illustrated the importance of trust in impacting upon knowledge sharing, which is then likely to lead to enhanced patient safety. High trust will enable OMGs to discuss problems they face, acquiring new knowledge or enhancing existing knowledge. Sharing a common understanding towards the achievement of common goals and outcomes is also important for knowledge sharing. When individuals have similar perceptions about interacting with one another, it can avoid possible misunderstandings and give greater opportunities to freely exchange their ideas. Having a supportive colleague to confide in has also been found to lead to increased job satisfaction and decreased stress in the job, helping OMGs to feel appreciated and ultimately increase retention.

Nigah *et al*[165] suggested an interaction between buddying, work engagement and *psychological capital (efficacy, hope, resilience, optimism*). Because buddying can be viewed as a job resource, it is likely to lead to increased psychological capital, which will then lead to increased engagement. Adding a socialisation element to the role can also increase the resource support that is offered. However, there may be challenges associated with buddying, including a lack of time and commitment, a lack of trust, inflexible relationships, and personality differences[166, 167].

Supervisory/peer support (in practice):

Kirwan and Birchell's model[145] highlights the relationship between ability to transfer and environmental factors such as support. Raising the cultural awareness of those working with OMGs is critical so that cultural differences are understood and support is offered where necessary (both on arrival and ongoing). Ensuring OMGs have a good supervision network is essential. Evidence suggests that supervisors are aware of weaknesses in OMGs but some are unwilling to document them or challenge trainees due to lack of ability to clearly describe the problem or for fear of being seen as racist or prejudiced[125]. Ensuring OMGs needs are understood and the support offered is at least adequate, can speed up adjustment and avoid any unnecessary problems arising. Support should not mean asking OMGs to compromise their own culture or values, but help them to overcome barriers in adjusting to new culture. This links to regognising their identity at the individual level.

As highlighted at the organisational level, OMGs need to feel able to ask questions when back on the ward after training and have the confidence to apply what they have learnt. OMGs may hold different interpretations and models of care may be different to those in the host country, however these may also act as a positive contribution and can be viewed as a competing discourse, rather than a conflicting one[151]. Peers can learn from OMG knowledge and experiences just as much as OMGs can learn from their peers, raising awareness and perhaps the performance of both parties.

Opportunity to perform:

As discussed in the theories described earlier, having the opportunity to perform (experiential learning) is critical to any training in order to increase both self-awareness and self-efficacy[143]. Many OMGs are simply not aware of what is expected of them (POD) and therefore may not feel they need to change their previous ways of practice. Therefore, the opportunity to perform in a safe environment will highlight their needs. It is important that OMGs will have the opportunity to apply what they have learnt after training when in practice. Therefore, colleagues and supervisors must aid in this, supporting the transfer of learning through ongoing feedback related to their needs.

Individuals from POD often felt inhibited in practice due to low self-efficacy. Colleagues were not always willing to help, or expected OMGs to know what they were doing. Such an atmosphere will only hinder transition. Unlike Baldwin & Ford's model, opportunity to 'use' (perform) is better placed at the training level in this theory.

3.6.4 Trainee characteristics (individual level)

Kirwin and Birchell's model gives personal capacity for transfer an important role in terms of the final transfer of learning[145]. They state that personal factors enable or inhibit the use of training, therefore the importance of trainee personal factors in terms of transition must be highlighted in the current research. Organisational and training factors may be in place to aid in the transfer of learning, but individual personal factors, such as culture and self-motivation, are likely to enable or inhibit this final transfer.

Self-motivation/incentives:

In terms of trainee factors, a great deal of focus is placed on motivation of the trainee to learn. This is likely to lead to learner readiness and enable individuals to transfer their learning, appearing in Kirwan and Birchell's model of transfer. Training needs assessment and expectations are likely to feed into this feeling of preparedness to learn. Ensuring

individuals hold the capacity to change[168] is needed to ensure insight (self-awareness) into personal strengths and weaknesses, which is also likely to aid in the motivation to improve[169].

However, OMGs may be purely motivated to take part in training to pass exams, rather than professional development. OMGs must be motivated to engage with both learning and application if they are to transfer new knowledge or skills into practice. OMGs may face negative experiences upon their arrival (such as lack of support, language barriers and vast cultural differences), which can adversely influence their learning attitudes, behaviours, and clinical performance[170].

Motivation for their migration can also impact OMG transition, there being different reasons why OMGs choose to practice in another country[151]. Whether educational, political or economic, each reason brings with it a series of difficulties, both for the individual and the society to which they move, as well as the society they leave behind. It is therefore inevitable that acculturation and period of 'settling down' will differ for everyone.

Acculturation explains the process of cultural change and psychological change that results following the meeting between cultures. Berry's fourfold model categorises acculturation strategies along two dimensions[68]. The first dimension involves the retention or rejection of an individual's minority or native culture (deciding whether to maintain one's identity and characteristics). The second dimension involves the adoption or rejection of the dominant host culture (deciding whether to maintain relationships with the larger society). Assimilation will occur if an individual adopts the cultural norms of the host culture, over their original culture. Separation will occur if an individual rejects the dominant host culture in favour of preserving their own culture. Integration will occur if individuals can adopt the cultural norms of the host culture but maintain their culture of origin. Marginalisation can also occur when individuals reject both their culture of origin and the dominant host culture. Coping strategies acquired through resources (at training level) are critical to transition as they can influence whether an individual accepts or rejects the new culture. Maintaining cultural and religious values, as well as maintaining relationships with those from their own culture, is important to OMGs[98].

Identity:

It is important that OMGs can maintain their professional identity and feel empowered within their role. Issues may arise if they are unable to use the skills acquired in their home country, and this may have a negative impact on wellbeing[12]. It may lead OMGs to feel

dissatisfied with life in the UK, which may influence them to leave. Therefore, support networks need to help in increasing Cultural Health Capital, as being affected by work relationships and environment restrictions can make things worse. Interactional difficulties and increased regulation of the health profession may lead to frustration and disappointment. Good Cultural Health Capital (CHC) is when OMGs can communicate cultural skills and attributes in ways that are usable and recognised by healthcare systems. OMGs may be able maintain their professional identity, whilst still practicing in a competent way and applying new knowledge. It is particularly important for highly skilled migrants[171], who have perhaps had to take up a lower grade post, that they do not lose their professional identity when practicing well below their level of skills and knowledge. It may be assumed that because they are coming in at a lower level, they are only capable at that level (if not lower), therefore they will not always be able to apply greater knowledge and skills. Continuing professional development is crucial for well-being[172], therefore OMGs must seek to do this and see opportunities of learning new practice, perhaps at a new level, in a positive light.

Interventions and support networks will only work if OMGs engage and are motivated to learn. Maintaining their identity will likely affect this. However, a strong sense of identity can be hard to maintain if facing other issues such as prejudice and discrimination. Evidence has repeatedly emerged that OMGs face discrimination at almost every stage of their medical careers[33]. It is often perceived that those who trained overseas have less knowledge than those trained in the host country. If the OMG is unable to communicate to a high enough standard, or they lack confidence in their communication skills, they may be dissuaded from asking or answering questions which may have a negative impact on their learning. The OMG may be seen to lack knowledge, when in fact they lack confidence. OMGs may also lack awareness, and therefore practice as they would at home. To host country graduates this is viewed as incompetent, when actually it is merely a lack of awareness and can be easily corrected. Such perceptions from colleagues can impact on both self-efficacy and self-identity of an individual, perhaps being sanctioned as a result of misunderstandings. Cultural acceptance is therefore key here, avoiding assumptions at both the training and organisational level.

Individual characteristics:

Individuals respond differently to the challenges they face during acculturation[173], whether having an intervention or not. Culture shock may be something that is influenced by

individual characteristics[51, 147]. Whether individuals learn and accept a new culture can be affected by factors such as age, gender, personality, education, nature of migration, and social, financial and personal resources[51].

Psychosocial processes which are co-constructed in sociocultural contexts are important here[174]. Hawthorne *et al*[175] have highlighted that OMGs from Commonwealth Asian nations are likely to encounter fewer barriers than those from other countries. This could be for many reasons, examples including level of training they receive, language, or how similar practice is in the host country.

Personality may play a key role in how individuals adjust, some naturally being more resilient and able to overcome obstacles. Workplace relationships may also be affected by personality. Improved intercultural communication and networks, discussed at the training level, are dependent upon each individual's ability or personality to make a large number of acquaintances. The quality of the relationships are just as important as establishing them. Those who have the ability or personality adapt quickly and more easily, whereas those who do not possess this ability, may struggle.

Self-monitoring:

Self-regulated learning can be described using the cyclical feedback loop, including self-motivation, goal setting and goal monitoring[176]. Goal planning is key here, however this will not take place if the motivational processes are absent. Self-monitoring is needed in OMG transition to increase self-awareness, empowerment and motivation. Learner responsibility must be taken if individuals are to continue to learn and transfer to practice[135]. Kirwin and Birchill also comment on demographic characteristics, job involvement, organisational commitment, personality and goal orientation which may impact upon how likely individuals are to self-monitor their progress and be motivated to learn[145]. This highlights the interaction between the three levels presented. Having access to self-monitored performance data is crucial to being able to accurately self-evaluate. As discussed at the training level, there is a need for the training design to ensure self-monitoring will take place through feedback and reflection.

Expectations:

Another area that was highlighted as being important during POD and discussions with key figures was whether there was a match between OMG expectations and organisational

expectations (see section 6.6.2). If OMGs arrive unaware of what is expected of them, it will make the process of acculturation much more difficult.

The absence of such information is likely to impact on readiness to learn. In contrast, OMGs may arrive with much higher expectations than what they are met with from the organisation. They may have expected a higher position, or did not realise the workload would be so high (due to high staff shortages). Such issues can impact on acculturation, motivation to learn (learner readiness) and potentially feelings of empowerment (not feeling in control of the situation).

3.7 Summary of initial middle-range theories

The overarching theory largely incorporates the three levels discussed by Baldwin & Ford[143] and the majority of aspects discussed by Kirwan and Birchall[145]. Other grand theories were explored and relevant aspects included, however the Transfer of training model offers structure and validity, whilst being applicable to the realist approach.

Organisational culture (climate), resources and leadership are thought to be critical if interventions are to be put into place effectively and then transferred back into the workplace (Figure 6.a). Organisations must ensure a sharing and questioning culture is created so that individuals have the confidence and trust to interact with colleagues and seniors. An effort must be made to manage the flow of knowledge and ensure that knowledge is easily accessible to those needing it. This can only happen if resources are available and disseminated.

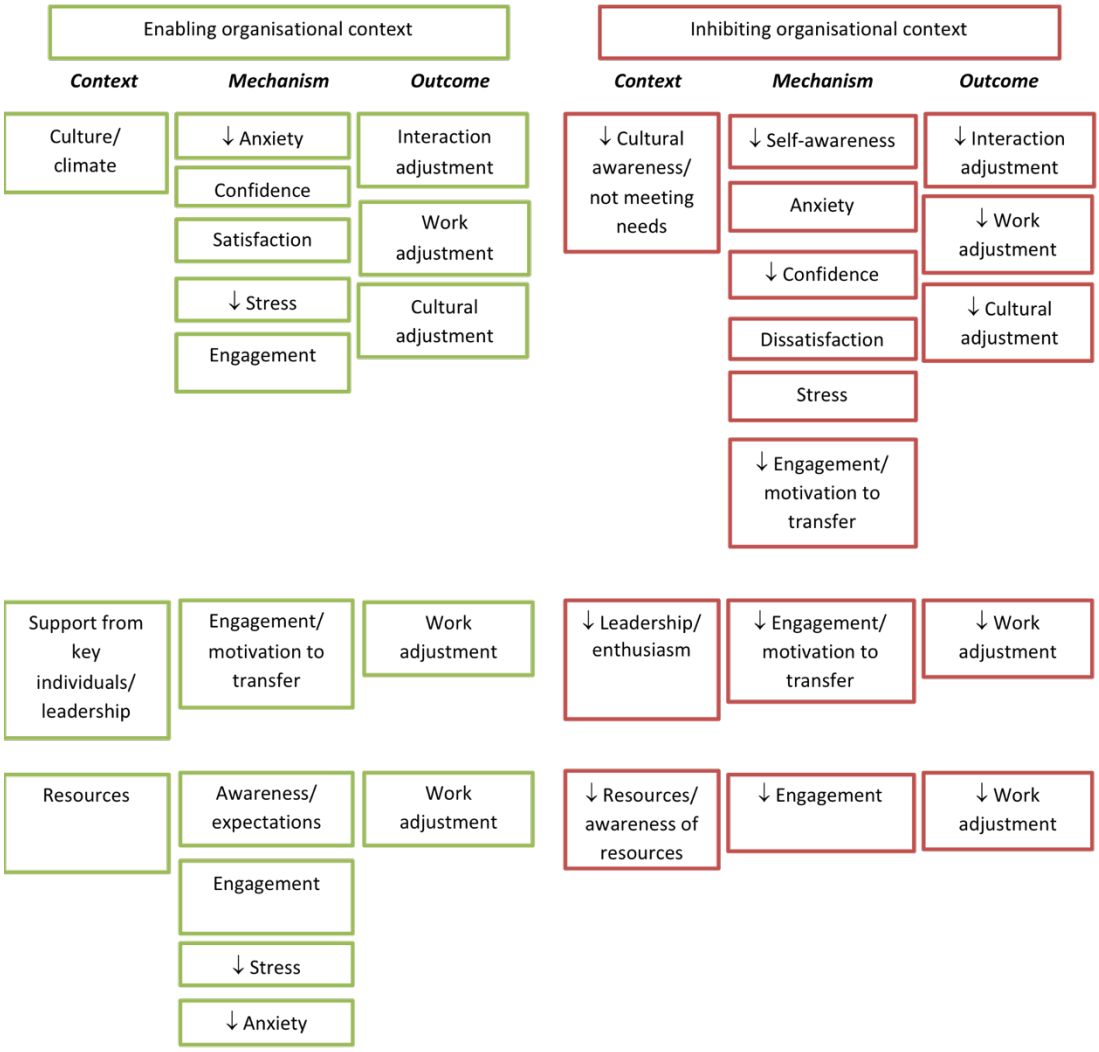


Figure 6.a. Organisational level middle-range theories derived from learning theories, adjustment theories, OMG literature, case study observations and discussions with key stakeholders

It is suggested that the practical design of the intervention should have valid content that addresses individual needs, considers the learning preferences of OMGs, and provides an opportunity to perform (Figure 6.b). Support from supervisors and peers may enable individuals to make the 'space' to transfer learning and build resources. As discussed, social capital facilitates exchange of knowledge, which can ultimately enhance patient safety[164]. Thus, strategies or mechanisms fostering a social networking climate will likely encourage knowledge sharing. Opportunities to apply learning through experiential scenarios, in both the training environment and in practice, are thought to be critical. This action learning will also give the opportunity for feedback and reflection.

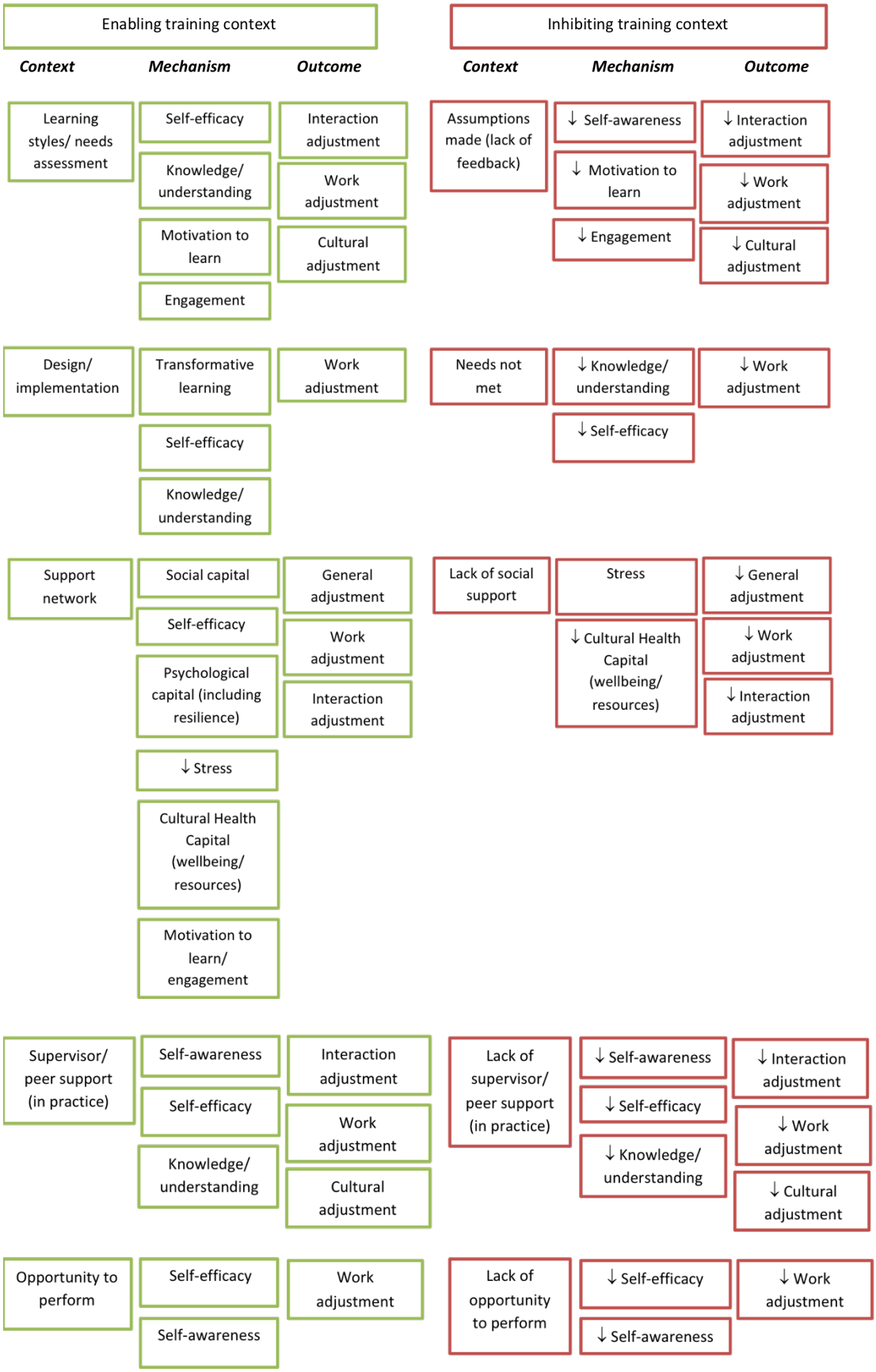


Figure 6.b. Training level middle-range theories derived from learning theories, adjustment theories, OMG literature, case study observations and discussions with key stakeholders. A better adjustment is likely to take place if interventions target this level alongside the organisational level (Figure 6.a)

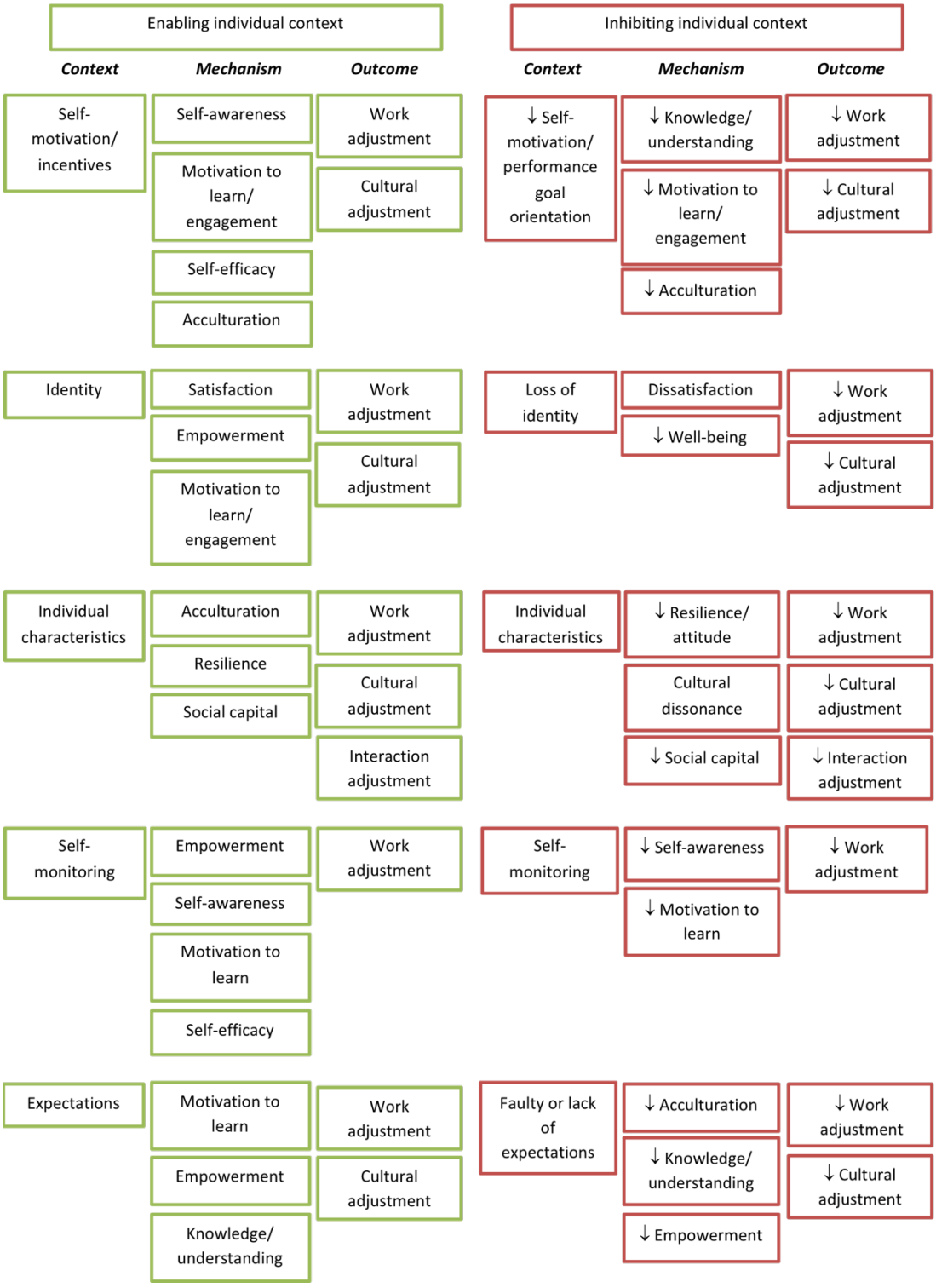


Figure 6.c. Individual level middle-range theories derived from learning theories, adjustment theories, OMG literature, case study observations and discussions with key stakeholders. A better adjustment is likely to take place if interventions target this level alongside the organisational level (Figure 6.a) and the training level (Figure 6.b)

Adjustment is also thought to be dependent on the individual (Figure 6.c). If the individual is resistant to learning or lacks motivation, then the learner is unlikely to allocate their personal

resources to learning (learner readiness) and will therefore impact on their speed of learning (work adjustment). The learner must be ready to learn and have the self-motivation and self-efficacy (self-efficacy developing at the training level) to apply the training into practice. Resistance to change from both organisation level and training level will likely impact upon individual factors such as self-motivation, identity, expectations and self-monitoring; ultimately reducing learner readiness and transfer.

The cog diagram below illustrates that there is an interaction between all three contextual levels (see Figure 7). Whilst individual, training and organisational structures may trigger differing mechanisms, there is likely to be a need for all levels to be in place if full adjustment is to be achieved. It highlights that if there is a change in one context, this can impact on other mechanisms and change outcomes. For example, if the individual is highly motivated to learn and engage, but there is a lack of support from the organisation to implement a well-developed intervention, the transitional outcome may not be as expected. Whilst on the other hand, if an organisation is supportive, but the individual lacks motivation, the individual cog will have greater resistance and will not turn effectively.

Figure 7. A cog diagram is used to illustrate that there is an interaction between all three contextual levels

Different aspects of the context may also interact with different components of the intervention to generate different mechanisms. A key question to address was how do people respond to these resources, given who they are, their backgrounds, and their

contextual constrainers and enablers. It is important to understand what contextual factors are needed for individual mechanisms to fire, which will lead to a successful transition.

3.8 Chapter summary

The initial theory has been described in detail, referring to evidence from OMG and transition literature, discussions with key figures, case study observations, and learning theories. A number of relevant learning theories that could have been applied to OMG learning were explored. The Transfer to Training model was chosen as the overarching theory that informed initial theory development about OMG transition. The assumptions of the initial theories were used to guide data extraction during the realist synthesis, presented in the next chapter, and tested through the synthesis of findings. Initial theory formulation was not intended to restrict theory development during the realist synthesis, but instead strengthen and refine key concepts. It aimed to illustrate coherence with previously developed models and push existing knowledge forward.

Chapter 4 Phase two of realist synthesis - Exploration of interventions used to support Overseas Medical Graduates' transition to their host country

4.1 Outline

The chapter begins by exploring the focus of the realist synthesis and research objectives. Both the methods and findings of the synthesis will be discussed, presenting evidence from the literature and case studies. In conducting the realist synthesis, the assumptions of the overarching theories discussed in Chapter 3 were tested against evidence. The chapter will conclude with the initial recommendations for implementation that were used to develop the Programme for Overseas Doctors (POD). A summary of the synthesis has been published in Medical Education[177].

4.2 Focus of the realist synthesis

Due to the lack of UK based research on interventions supporting OMGs[43] (highlighted in Chapter 1), the UK could not be the sole focus of the current synthesis. It was also important to examine and learn from experiences in other countries[97], such as Australia or Canada, where research in this area is more extensive in comparison and can aid in theory building.

Although the focus of this synthesis is on medical graduates, graduates from other health care professions have not been excluded from the analysis. Lessons learned from looking at common forms of intervention across the health care professions can help us to further understand the conditions in which the interventions trigger differing mechanisms to generate both wanted and unwanted outcomes. It has also been noted that lessons learnt from findings of transition interventions for OMGs may be applicable across healthcare professions[178]. In fact, it is seen as 'fruitful' to collaborate both within medical education and from other fields[53].

This is particularly important given that insufficient evaluation has been noted[53], meaning that interventions for OMGs may not be working as intended. Satisfaction surveys of participants do not lead to sufficient evaluation, but seem to be the main source of feedback. In fact, this feedback may not illustrate what the learners truly felt[99], since they may not want to be critical and jeopardise their position. Furthermore, participant satisfaction cannot be relied upon to tell us whether a transition has been made, this largely depending on performance and behaviours in the workplace. Evaluation is an essential step in curriculum

or intervention development[179], but is not always given prominence, as resources are often directed towards implementation. When more adequate evaluation does take place, the focus is largely on effectiveness or worth, failing to advance theory or applied understanding of OMG transition. A recent systematic review on this subject recommended an exploration of theory and evidence[53]. The processes of effective transition at the workplace level have, up until now, been taken for granted[180, 181]. Long-term outcomes cannot be achieved without understanding successful structure and process. As discussed, theory helps researchers to consider key variables and can lead to conclusions that are more generalisable; 'there is nothing so practical as a good theory'[182]. We cannot offer solutions to an issue without fully understanding the process. Rigorous evaluation of the process will also ensure that interventions are worth the investment in both time and resources.

The inter-relationships between the different contextual levels were also explored. The focus was not just on workplace performance, but overall transition. It was hoped that by identifying more abstract middle-range theories, evidence could be collected from other domains and lessons learnt could be developed and promoted for use in other healthcare practices.

4.3 Research objectives

This synthesis sought to explore and synthesise evidence relating to interventions developed for OMGs. It aimed to provide educators and policy makers with an understanding of how interventions should be developed to support OMGs in their transition to the UK workplace, particularly looking to identify how and why they are effective. Question selection was crucial to pinpoint key processes for investigation. The following were kept brief so that data extraction was not constrained:

SPECIFIC QUESTIONS:

- What interventions have been used to support the transition of overseas graduates to the host country workplace?
- How and why are they effective?
- What factors are important to achieve a successful transition?
- Are they hindered by various barriers suggested in previous findings within the literature?
- What theory explains why interventions are successful and can support wider future interventions?

4.4 Methods

A realist synthesis method was chosen in order to help the researcher to identify programme theories, key intervention components and explore the initial middle-range theories presented in Chapter 3. The aim of the synthesis was to interrogate the existing evidence to find out whether and where the proposed theories were evident, identifying conflicting evidence and developing the overarching theory. The realist approach has been described in detail in Chapter 2.

4.4.1 Design

As discussed in the previous chapters, it was decided that instead of conducting a traditional systematic review, a realist approach was more fit for purpose. The effectiveness of interventions used within healthcare practice can vary depending on a variety of factors; including amongst others context, the implementation process and participants. Realist synthesis deconstructs complex interventions to understand contextual factors that affect intervention success and what mechanisms drive change, resulting in an individual's actions or outcomes. The lack of robust evidence and evaluation of interventions also limited the amount of literature available to include in a systematic literature review

Complexity is acknowledged throughout in the task of scouring the evidence base. The success of developing programme theory is not simply a question of the value of the interventions underlying ideas, but depends on the individuals, interpersonal relationships, institutions and infrastructures through which, and in which, the intervention is delivered. The realist approach therefore differs from traditional systematic reviews in that it asserts that sources should not be limited to primary (or secondary) data, but should include grey literature, such as administrative records, annual reports, policy, or personal testimony[1]. This helps to build up a fuller picture as to how various combinations of contexts and circumstance can amplify intervention success.

This synthesis therefore aided in capturing the complexity of interventions for OMGs, rather than focusing merely on the outcomes. The findings of the review were fed to stakeholders' stage-by-stage and theory-by-theory, and impacted on the implementation of POD (discussed in detail in Chapter 6). As will be illustrated, POD changed over time and the revised version was very different from many of the interventions evident in the literature. This highlights the iterative nature and importance of the realist approach. Impact on local and regional interventions is also discussed later in the thesis.

Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) quality standards were used to guide the method of this realist synthesis, the researcher ensuring all phases were in line with the quality standards developed[124, 183].

4.4.2 Data sources and searches

With the help of an information scientist, an initial systematic search was conducted to identify relevant evidence. The databases searched included Medline, PsycINFO, EMBASE and Educational Resource Information Centre (ERIC). Terms were agreed upon during the development of initial grand and middle-range theories used to guide the synthesis and data extraction. These are presented in Box 2. As discussed, it was decided that analysis would be enriched by the inclusion of grey literature, descriptive studies and theoretical papers.

The results were filtered by title and then abstract. A random sample (10%) was selected and assessed by other members of my supervisory team to ensure quality assurance[124]. Papers were tentatively coded for rigour and relevance at the initial stage[124], and key findings and themes highlighted. A record of the search process was kept throughout; noting the number of papers obtained or deleted.

Box 2. Search terms

OMG terms

Overseas doctor* OR International Medical Graduate* OR IMG* OR non-UK graduate* OR non-UK qualified OR Overseas Medical Graduate* OR Overseas Graduate OR foreign doctor* OR immigrant doctor

Intervention terms

Support OR training OR induction OR program* OR intervention OR introduction OR orientation

Specific interventions terms

Simulation OR buddy* OR mentor* OR shadow*

4.4.2.1 Inclusion and exclusion criteria

Titles and abstracts were considered against the inclusion and exclusion criteria in Table 2. All duplicates were removed. Contact was made with authors via e-mail to retrieve evaluations that had been referred to in the article but not published, or when further information was required. Wong *et al*[183] suggest identifying clusters of rich papers, a single article being unlikely to contain sufficient conceptual and contextual detail. Individual articles

are often constrained by journal word limits and so will not enable the researcher to develop a rich and full understanding of the theory. Sibling papers were sought where possible.

Table 2. Table of inclusion and exclusion criteria

Inclusion	**Exclusion**
Intervention within healthcare setting	Limited description of intervention
Target population is overseas graduates	Limited analysis/results (intervention not ran)
Relevant intervention (transition/support)	Published before 1990
Full article	Not in English Language
Papers may be opinion based/suggestions through research	Not within healthcare setting
Case Studies not published in literature	Intervention aim is not to aid transition
Must be focused on overseas graduates	Undergraduate university programme
Any country considered	Focus of intervention should not be competency/knowledge based only
Any duration (aim being transition/support throughout)	Findings are not focused on overseas graduates

Sources were not excluded based on their study design[184], as potentially relevant papers could be missed. The nature of the realist approach meant that intervention processes, rather than outcomes, were the focus. All studies that could potentially add to theory development were included[183]. As discussed, the search inclusion criteria were revised to include all overseas healthcare graduates, not just medical graduates. If an abstract met the criteria, the full paper was retrieved.

4.4.3 Data analysis and synthesis

The initial theories presented in Chapter 3 were used to guide data extraction. Data were extracted from each study using a template that included study information, CMOcs, relevant theory, and an assessment of relevance and rigour. Relevance and rigour were assessed on a scale of 1–5 for each paper (see Box 3). Articles low on relevance and rigour (i.e. scored 2 or less) were generally excluded. However, descriptive pieces that provided rich

data and added to theory development (high on relevance but low on rigour) were included[184]. There did not necessarily have to be clear CMOcs, some parts of the data being particularly useful for certain aspects of the theory. On occasions, outcomes were implied from the mechanisms highlighted rather than explicitly stated. This process ensured transparency. Extracted CMOCs were inputted into an Excel spread sheet for further analysis.

Box 3. Scale used for assessing relevance and rigour of papers

Test relevance (Is the evidence provided in this theory area relevant enough to be included in the synthesis?)

5 - Direct relevance to transition interventions that had been evaluated within a healthcare context and can therefore contribute to theory building and/or testing

4 – Relevance to transition interventions (provides evidence around theory, has not necessarily been fully evaluated)

3 – Relevant concepts and theories

2 – Potentially relevant concepts and theories

1 – Does not address the theory under test (no relevance can be made to transition)

Test rigour –

5 - Methods used to generate the relevant data are credible and trustworthy and fully support the theory

4 - The research supports the conclusions drawn from it by the researchers or the reviewers but methodology could be improved

3 – Provides valuable contribution to the conclusions drawn, despite some flaws in methodology

2 – Provides some contribution to conclusions drawn despite poor methodology

1 - Methods used to generate the relevant data are not credible and untrustworthy and provide no contribution to any conclusions drawn

Data synthesis involved refinement of the CMOcs and the generating of hypotheses. Searching was largely iterative because, as the synthesis progressed, new or refined elements of the theory were required to explain particular findings, or to examine specific aspects of particular processes (see secondary search). Results were extensively shared and reviewed with key stakeholders (Clinical Directors and policy makers), intervention planning teams from health care organisations, OMGs, educators, UK doctors, educational directors and tutors. Discussions took place concerning issues such as competing theories. With the realist approach, there is no uniform mode of synthesis[184].

Several realist experts from RAMESES were contacted at appropriate times to provide guidance on the realist methodology, developing CMOcs and developing theory. A sample of the CMO templates were also assessed by three realist researchers to ensure that the

researcher was documenting the CMOcs appropriately and not being too judgemental. It was suggested that more of a link between the C-M-O data be highlighted, rather than document each separately, this leading to CMO 'soup' if not careful and making the analysis stage much more of a challenge. It was also suggested that the researcher not be either positive or negative in the CMOcs, but maintain neutral terminology that could then be explored using the positive and negative data.

4.4.4 Case studies

Interventions were identified at the synthesis stage, from grey literature and hand searching (primarily within the UK), and were developed into case studies to aid theory refinement (a 'reality check'). It was recognised at an early stage that not many studies have been published within UK, therefore it was important to see if theories were applicable in the UK context. Organisations implementing the interventions were contacted, and where possible, they were observed. Discussions were held with OMGs and those involved in intervention development and implementation. Where the researcher was unable to attend, detailed discussions with the intervention leads and medical educators were conducted. The case studies enabled further exploration of inconsistencies to test programme theories and ensure maximum variation[184]. CMO patterns were recorded in an excel spreadsheet in the same way described above.

4.4.5 Secondary search

As new elements of theory developed from the data, secondary searches were needed to support and refine the new areas of interest further[184]. The nature of the realist perspective meant that there was no restriction to the domain of interventions for OMGs, mechanisms being seen as 'portable'. The unit of analysis was the programme theory, not the intervention. There was much to be learned from looking across intervention types[110], a single pre-defined search in fact being seen as insufficient[183]. Focused searches of the literature therefore took place. This allowed the exploration of evidence external to OMG transition, such as more general simulation training, peer support, audit and feedback, benchmarking, and 'naming and shaming'. Findings that could potentially lead to insightful and practical discoveries, to help understand the chemistry of intervention operation, were sought[53]. This also led to exploration of other grand theories from areas such as sociology, psychology and economics. More general principles and ideas were therefore gathered about how the included families of interventions may work. Bringing together all grand

theories, programme theories developed through initial and secondary searches, and ongoing discussions, led to refinement of initial middle-range theories.

4.5 Findings

The initial search yielded 4124 results. Figure 8 illustrates the filtering process that resulted in 62 papers being included.

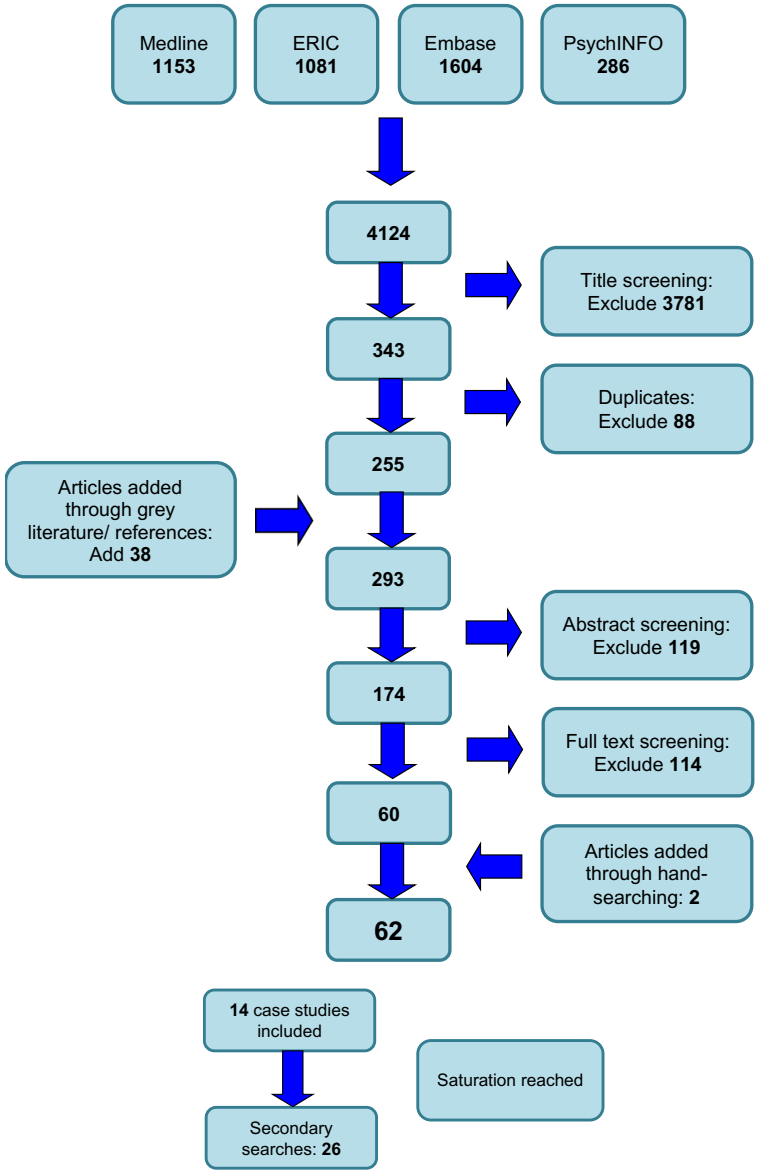


Figure 8. Diagram of search results

Twenty-six papers were added through secondary searches (total 88 papers).

4.5.1 Study characteristics

Detailed study characteristics are presented in the Appendix 1, which presents the location, healthcare setting, participants, intervention, intervention type, study design and duration.

The interventions included communication and linguistic skills courses, acculturation courses, examination workshops, cultural and social skills workshops, shadowing, bridging programmes, pre-employment programmes, inductions, orientations, buddying interventions, peer support, supervised practice, 'observerships', simulation and web-based resources. The articles found were from Australia, Canada, the USA and the UK.

Of the 62 papers, 48 reported on doctors and 13 on nurses who graduated outside of the host country. One addressed physiotherapists. The duration of these interventions ranged from a 1-day course (5 hours) to 3 years of training. The majority of the interventions were implemented across a number of weeks or months and included a variety of components and levels of support. All but one of the 62 papers offered ongoing support in some way, whether through support groups, buddies or ongoing training. Many regarded successful interventions to be between 3 and 5 days in length[99]. Different kinds of transition (e.g. social and work) were generally addressed separately. The interventions focused on differing stages of transition: prior to starting work, beginning practice, and ongoing throughout employment.

Although some papers were based on rigorous evaluations of the interventions, others were merely descriptive (16 papers) and reported no outcome data. Others were small scale ($n \leq 15$) or focused on one intervention in a single setting. Both qualitative and quantitative methodologies were used, the majority consisting of self-assessment tests before and after interventions.

The 26 articles included from secondary searches included buddying, simulation and web-based interventions. Saturation was reached at this point as no other themes were identified to support theory development and refinement[184].

4.5.2 Case study characteristics

Fourteen case studies were included in this synthesis. Each case study (CS) has been numbered and details of their duration are presented in Table 3. Interventions developed in the UK have generally been delivered over 1 day (or less). One exception was CS1 (POD), which as discussed previously was a 5-day training programme. The three case studies from outside the UK offered ongoing support. Those from the UK largely lacked ongoing support.

The case studies relied on participant feedback, but failed to evaluate the interventions independently. All but one of the interventions were aimed at doctors.

Table 3. Case study characteristics (note: Health Education England North East (HEENE) was formerly Health Education North East (HENE)

Case Study	Organisation	Year	Duration	Intervention
1	University Hospital of North Tees (UHNT)	2013	5 days	Enhanced Shadowing Programme (POD) (Pilot 1)
2	University Hospital of North Tees (UHNT)	2014	2 days	Programme for Overseas Doctors (POD) (Pilot 2)
3	University Hospital of North Tees (UHNT)	2014	2 days	Programme for Overseas Doctors (POD) (Pilot 3)
4	College of Physicians and Surgeons of Nova Scotia	2013	5 days	Clinician Assessment For Practice Program (CAPP)
5	Health Education North East (HENE)	2010-2013	1 day	Support for overseas doctors new to clinical practice in the UK
6	Health Education England North East (HEENE)	2014	1 day (one day follow)	Support for overseas doctors new to clinical practice in the UK
7	Registered Nurses Professional Development Centre	2012	8 sessions, 1 per week (3 hours - 6-9pm)	Orientation to the Canadian Health Care System
8	London Deanery	2014	Online package	E-learning Induction Package for International Medical Graduates and EU doctors
9	Central Manchester University Hospital	2014	Online/ongoing	Online induction and support system (peer 'buddy' support and educational supervisors)
10	General Medical Council (GMC)	2013	1 day	Welcome to UK Practice
11	Aukland District Health Board (ADHB)	2011	26 weeks	Ready-for-Work Training Programme
12	Yorkshire and the Humber Foundation School	2014	1 day	Induction to NHS
13	British Medical Association (BMA)	2015	Half day	Welcome to UK Practice seminar
14	Health Education England North East (HEENE)	2015	1 day	Communication Skills for Doctors New to UK Practice

4.5.3 Refined middle-range theories

The presentations of findings from this synthesis are framed around the three contextual levels derived from the initial middle-range theories (Figure 9). The three levels (organisational, training and individual) will be described in detail, highlighting how the differing contextual factors (C) may facilitate or hinder transition, by referring to the relevant mechanisms (M) and outcomes (O).

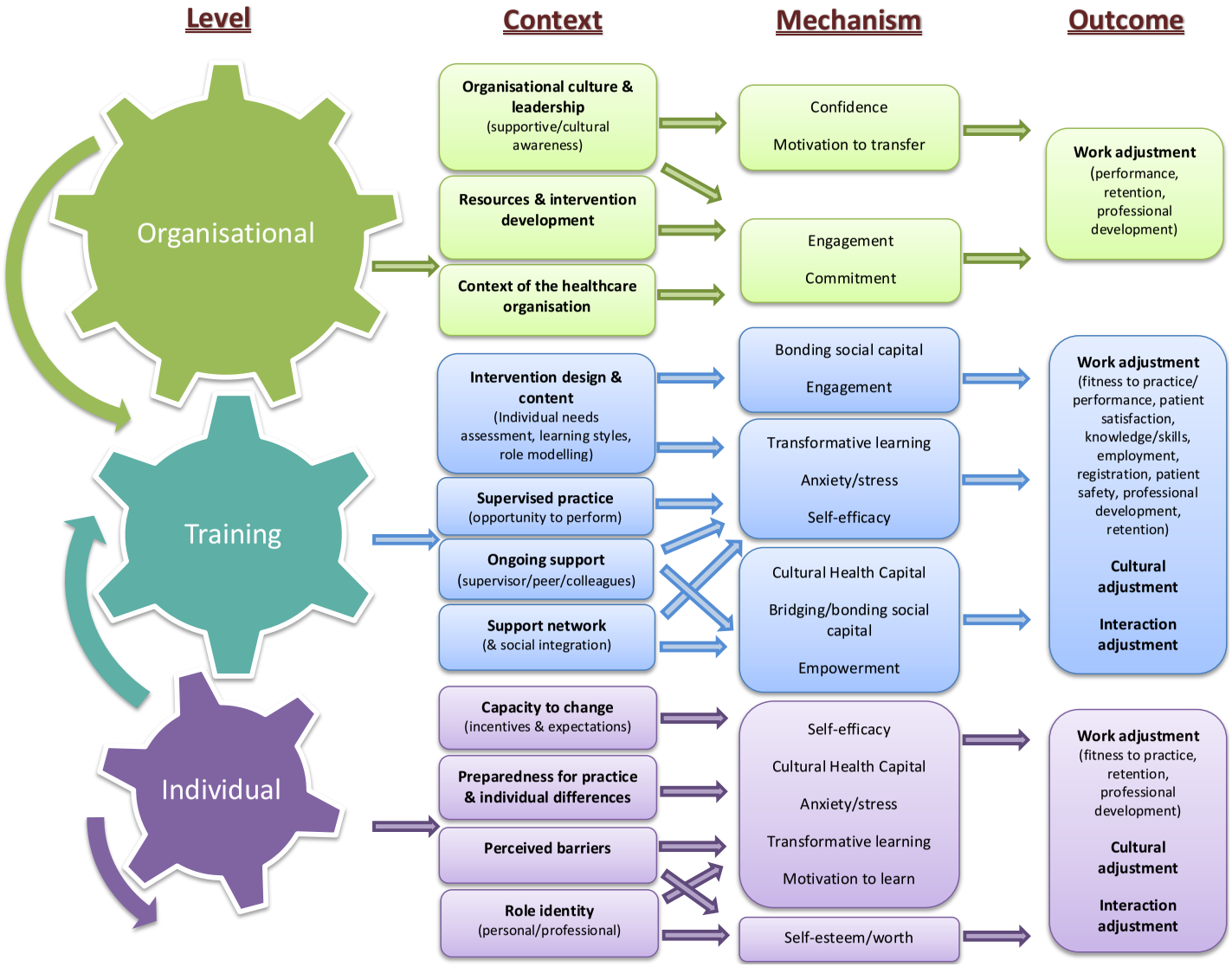


Figure 9. Refined middle-range theories illustrating factors impacting upon OMG transition

4.5.3.1 Overview of outcomes

Most of the primary outcomes found in this synthesis were related to work adjustment. Outcomes included performance[14, 185-196], patient safety[83], quality of care and patient satisfaction[187, 188], retention[165, 187, 197-200], staff satisfaction[201, 202], passing of assessments and registration[89, 158, 203, 204], and employment[158, 178, 195, 201, 205]. Outcomes in terms of adjustment to life in a new country were not generally focused on, although cultural awareness was reported[206]. Adjustment within interactions occurred through specific communication skills training and interaction with colleagues[186, 192]. Cultural adjustment was largely addressed through training and the development of support networks[190, 206]. Both interaction and cultural adjustments were often inferred. General adjustment was removed as an outcome from the synthesis due to a lack of evidence for this.

4.5.3.2 Contextual factors of the organisation

Organisational culture:

The need for intercultural awareness within an organisation was found to be essential (C)[88, 89, 98, 178, 186, 188, 195, 207-210] as OMGs arrive with differing cultural experiences and expectations that can have an impact on both learning and practice[204]. Organisations need to hold realistic expectations and not make assumptions[202] either that OMGs can simply move into practice without extra support[54, 211, 212] or cannot practice competently upon arrival[194, 213] (CS1-3). The majority of the articles acknowledged that organisations must take responsibility and be responsive to the needs of both OMGs and their institution[14, 73, 98, 102, 158, 178, 181, 195, 197, 200, 201, 203, 205, 207, 214-231] (CS1-10, 13), understanding how OMGs have previously practised (C). Organisations need to understand how OMGs are coping and accept that this group may have vulnerabilities, and handle this sensitively without being patronising or creating a sense of stigma (C) (CS1). Interventions should therefore reflect this. Through organisational induction, support groups, reflection and ongoing evaluation of OMGs' adjustment[99], a healthier and culturally rich learning environment can be created[51] for work adjustment to occur (O).

However, during CS1, not all individuals responded well to being offered support from a 'differing needs' fellow, perhaps due to feeling of unacceptance and low confidence (discussed later) (M). A lack of confidence and anxiety around stigma (M) is also likely to occur if employers treat OMGs as second-rate employees[51]. OMGs often felt they were there to fill jobs nobody wanted[51]. OMGs must be given the same training opportunities as others in order to feel accepted.

Feeling unaccepted can lead to a sense of self-blame e.g. feeling that a lack of friendship is due to their behaviours and perceived differences (M) (CS6). Yet on the other hand, individuals may blame the difficulties they face on the environment in which they are working. This is linked to individual differences (also discussed later). These negative feelings about the organisation will inevitably lead to reduced engagement (as demonstrated above) and confidence that the organisation can help them (M) (CS5, 6). A supportive environment, becoming part of the organisations culture (C), is needed to help overcome such issues. OMGs need to feel confident (M) that the organisation in which they are working provides necessary support, ultimately leading to retention and high overall performance (O) [158, 185, 192, 209, 217] (CS3). Both supervisors and colleagues may benefit from cultural awareness training (C)[195, 222, 232, 233] (CS1, 6). Support from these figures will likely impact upon OMG motivation to transfer their learning (M) (CS3).

Those working with OMGs must be made aware that they can bring both multiple perspectives and strengths to practice (C). Host country graduates can in fact utilise the differences to aid their own learning[54], enabling a better relationship to be established through learning from one another (O). Creating this sense of equal power seems to be important, creating the message that OMGs are not expected to lose their own cultural traditions completely and only adopt new ones (M). Past experiences should be acknowledged and cultural opinions not imposed (C). OMGs should instead have the opportunity to build on their competencies, and not feel they must 'unlearn' what was previously known. A focus purely on host country culture can be detrimental to OMGs' transition (O)[204], creating a feeling of competing values and beliefs. Organisations should also make adjustments for religious or cultural requirements (C)[219], perhaps helping to overcome such issues of acceptance (M).

Leadership:

A key individual, who thoroughly understands the needs of OMGs, will push interventions forward and will strive for organisational change (C). This was found to be crucial in a number of studies[14, 102, 158, 178, 179, 185-187, 209, 229, 231, 234] (CS1-3, 6, 9, 11, 12). It is acknowledged that there is a lack of time, resources and commitment in many cases, but an enthusiast can increase overall organisational support (CS2, 3, 6). This will enable sustainability, with the ultimate goal being that interventions become socially situated in practice and built into work schedules. This level of support will ultimately impact on the quality of training developed. Full commitment is needed for long term interventions that provide ongoing support. A lack

of leadership is often a reason why buddying fails, its ongoing nature requiring a great deal of commitment that was previously identified (CS1, 2, 5). Interventions that are easiest to organise and deliver are often favoured by the organisation.

Resources:

The amount of resources invested into OMGs' transition inevitably had an impact on the characteristics of the interventions offered[54, 85, 88, 158, 186-188, 191, 197, 198, 201, 203, 208, 209, 215, 218, 222, 224, 226, 231, 232, 235-240] (CS1-4, 7–9, 11). As a result of the high cost, lack of time, practicalities and inflexibility[185, 236], ongoing support may be problematic. Interventions are therefore guided by available resources (C)[214]. Many failed attempts are the result of a lack of resources and time[195, 204], causing interventions to be implemented half-heartedly.

Thorough and comprehensive interventions are needed to aid transition[229] (O). Although a 1-day induction is better than nothing (CS5, 6, 10), it can be viewed as more of a 'welcome', not offering the ongoing support needed (C)[66, 192, 216, 221, 240] (CS12). Although resource intensive[14], stakeholders need to balance improved efficiency of OMGs against the amount of work carried out[195, 217]. OMGs report a preference for a longer orientation[200] ensuring a higher level of both engagement in the acculturation process (M) (CS3) and overall benefits to adjustment (O)[214, 240]. Implementing quality training also illustrates organisational support and acknowledgement of OMG needs, likely leading to higher levels of motivation to transfer learning from OMGs (M).

Organisations should therefore aim to draw upon local faculty members[88, 102, 194, 218], embedding interventions into their normal practice to reduce cost[225] (C). The use of external resources, for example during POD, meant that the intervention was unlikely to be sustainable and the example of good practice would not be adopted by other organisations. If the interventions are not cost effective and time efficient [178, 179, 211, 241], resources will not be made available for future interventions (C). A sharing of best practice and resources between institutions is therefore needed (C)[201, 223, 224], helping to promote attendance[209, 223] and likely resulting in increased cost-effectiveness[158]. If an intervention is promoted outside of the institute, resource support from externals may also be provided[242].

Due to pressures of clinical duties, cognitive overload must be taken into consideration[99] (CS4), intensive interventions perhaps being seen as extra work by OMGs (C), reducing engagement (M). Engagement with the intervention may also decrease if OMGs lack the income to support attendance (C)[73, 205]. Many need income to support the living costs of both themselves and their families[98]; therefore charging a fee to attend is likely to reduce

engagement further (M)[83, 158, 178, 185, 200, 201, 218, 233] (CS5, 6, 14). Financial and practical support, such as accommodation and transport was offered in some cases[99, 201]. The aim of this was to reduce the stress and financial hardship (M). However, the sustainability of this is uncertain. Whilst such funding is likely to increase commitment to the organisation in the long run (M), the cost is high (C).

Whilst attendance may be lower for those who are charged a fee, those who pay to attend may be more motivated (M). However, where OMGs were placed on wards to learn, feelings of exploitation arose for some[214], feeling that colleagues used their 'free' service in a way that was not necessarily fair. This may hinder engagement and commitment to learning in this environment (M).

In order to increase attendance, it may be beneficial to run training interventions more than once[228], catching those that start work at differing points throughout the year. However, this is again dependent on available resources

Context of the health care organisation:

The organisational context was found to affect the learning and overall adjustment of OMGs[99, 158, 178, 185, 200, 224, 225, 228, 229, 243, 244] (CS9); examples including training site (e.g. rural), type of specialty and level of training[179, 233, 244, 245] (C). OMGs are often appointed to posts that are difficult to fill and therefore they may not get placements in specialties of their choice or in a preferred location (C). Some specialties are primarily being filled by OMGs, mainly those where recruitment is low, thus there is sometimes a sense of stigma associated with certain specialties.

Transition can be difficult if the area in which an OMG is working does not offer the necessary resources. This is likely to result in a reduction of both commitment and engagement (M), leaving OMGs more 'at risk' (O)[226]. For example, rural areas may not be ethnically diverse and may not meet cultural needs, leading to feelings of isolation (M)[246] which may lead the individual to return home (O). Conversely, smaller communities may in fact provide a good transitional environment if there is a supportive atmosphere and a sense of teamwork (C)[224]. In comparison to larger organisations, where OMGs may get lost in the system and support is limited (C). Location was also found to hinder ease of access to interventions transition[179] (CS5, 14).

OMGs must identify with the local community (C)[98, 209] and recognise the different types of patients' needs, social norms and colloquial language that may be specific to that area (M)[194,

[223]. Such issues must be taken into consideration, ensuring that OMGs engage in the necessary training (M), for the wellbeing of both the OMG and the patient (O).

Intervention development:

Organisations often fail to implement successful interventions because of poor development (C) (CS12), thus reducing the engagement of OMGs (M), who may feel their needs have not been addressed, and leading organisations to give up. However, thorough planning, a review of the literature and theory and responsiveness to changing needs[54, 158, 227] will undoubtedly improve the chance of success. Interventions should not be implemented as a 'tick box' or for convenience[209]. A steering group (including OMGs and experts), a pilot intervention and ongoing evaluation and development were found to be necessary[88, 102, 158, 178, 185, 186, 194-197, 200-206] to meet the needs of OMGs (O)[66, 73, 85, 179, 210, 212, 214-217, 220, 222-224, 228-231, 233, 238, 239, 241] (CS1-8, 10, 12-13). Such commitment to ensuring a successful intervention is implemented will have a positive effect on OMGs attending[226], likely resulting in commitment from them to the institution (M).

Evidence suggests that there needs to be a better human resources (HR) process for identifying new OMGs within each organization[61, 83, 89, 102, 185, 195, 200, 201, 212, 215, 217, 218, 220, 222, 228, 229] (CS3, 4, 6-8, 14), to ensure appropriate support and induction is put in place as early as possible and for all who require it (C)[194]. Organisations are not always aware of their arrival until they are in the country. This is despite the observation that the dissemination of information in advance is crucial to the engagement of OMGs and to raising awareness of potential difficulties they may face (M). Information packs sent prior to arrival in the host country may also aid adjustment to work (O)[225, 241] through reducing anxiety (M), adding to perceived support and increasing initial commitment to the organisation (O)[228]. These information packs can target OMGs at the earliest phase of their transition (before arrival) and capture those who start outside of normal contractual dates[241]. It is also important for those with families to know what is to be expected when they move to the host country (CS6). Although not all OMGs will engage with this information prior to arrival[241], the option should at least be there[226].

Online resources are an effective way to provide initial information and ongoing support (C) that can facilitate learning (M) and professional development (O)[234]. Online resources are particularly useful where initial information or intervention are lacking, and increase ease of access[158, 178, 181, 217, 226, 227, 230, 242]. However, some studies reported the dissemination of such information to be poor[225] (CS1, 14).

It is reported that OMGs were not always able to participate in interventions due to high workload on their ward (CS5, 14), demonstrating that perhaps the crucial need for the intervention is not understood. Therefore, making interventions mandatory[83, 158, 185, 194, 200, 215-217, 221, 229, 237, 238] (CS3, 4, 9) may overcome such issues. Commitments often get in the way when interventions are made voluntary[230] and may perhaps not capture all of those in need of the intervention[186]. Those lacking insight may not see the need for the intervention and not participate. Although voluntary participants are likely to be highly engaged and motivated to transfer; recognising their needs[14, 54, 61, 73, 85, 187, 197, 211, 225, 247] (CS5, 8, 12, 13), a mandatory intervention is more likely to capture those with greatest needs.

It is also clear that OMGs are often given less support if they are not in training posts, interventions often being established primarily for those in a new training post (CS5, 10). Those coming in at higher posts are likely to be missed. Locum doctors are another group largely unsupported (CS14). Those OMGs outside of training posts would benefit a great deal from information prior to starting work, often being more isolated than those in training (CS1, 5).

4.5.3.3 Contextual factors of training: intervention

Individual needs assessment:

The findings highlight the importance of individual needs assessment, particularly when conducted upon arrival, before any intervention is implemented[228] (C)[61, 66, 73, 83, 85, 89, 91, 98, 158, 179, 185-188, 190, 191, 194-197, 201, 203-205, 208-210, 213-215, 217-220, 223, 224, 227, 229, 235, 236, 239, 241, 248] (CS2-4, 7, 9). This enables training to be tailored[202, 216, 226] and support given where necessary (CS9). OMGs will only benefit from training that is relevant and meaningful (C)[88, 99]. Increased *transformative learning* (*self-awareness, beliefs, behavioural*) and engagement is likely to result from an initial needs assessment (M)[145, 194, 216]. Organisations need to take account of the individual past experiences of OMGs within different health care systems and social and cultural contexts (C)[215]. Although all attending are from overseas, they will have differences in terms of culture, gender, religious and political beliefs, personality, and individual circumstances (discussed at the individual level). Being aware of personal learning needs enables OMGs to reflect on these in practice (M), aiding their professional development (CS9) and resulting behaviours (O)[248].

Environment and learning preferences:

A safe environment, which is low risk and controlled, was important when implementing interventions for OMGs (C)[14, 61, 83, 91, 102, 187, 188, 197, 201, 206, 211, 215, 218, 219, 225, 231, 234-237, 241, 247, 249, 250

(CS1-7, 10-11, 13). OMGs must feel able to recognise and admit mistakes, and share challenges without fear, reducing anxiety both during the intervention and in practice (M)[191, 206]. Learning in such an environment will likely aid work adjustment (O).

Learning is both an individual and social experience and small group discussion and peer feedback are essential (C)[14, 61, 85, 102, 178, 185, 186, 188, 194, 197, 204-206, 213, 215-218, 220, 223, 229, 232, 233, 235, 239, 240, 244, 247, 250, 251] (CS1-3, 6, 10, 14), as they promote self-reflection and self-awareness (transformative learning)[206] (M). Engagement is much more likely to occur in small groups than in larger groups (M)[212] once initial shyness is overcome[220, 239]. Identity formation within the group is also likely to occur (M) through sharing of stories and experiences[220], aiding both work and cultural adjustment (O). Self-efficacy should increase (M)[185, 239, 244] (CS2), as OMGs are less likely to blame themselves when they acknowledge that others are facing similar difficulties. In sharing experiences and reflecting on their own practice (C), OMGs' engagement and levels of *Cultural Health Capital (wellbeing, resources, resilience, optimism)*[12] will also increase (M)[206], benefiting their practice (O).

Experiential learning, with feedback and reflection, played a substantial role in the majority of interventions[14, 83, 85, 89, 158, 165, 178, 181, 185, 191, 194, 197, 201, 203, 205, 210, 211, 214, 215, 218, 220-222, 224-226, 228, 229, 233, 235, 238, 240, 241, 244, 247, 250, 252] (CS1-3, 7, 11, 13). Examples included simulation[212, 227] and role play[251] (CS1-3), which created active participation (C). Such interventions ensure experiences can be standardised and consistent. Simulation can be a powerful tool in changing behaviour and improving clinical knowledge, as well as communication and teamwork skills (including multi-professional) (M)[191, 235], which can be difficult to address using other learning methods. This experiential learning enables OMGs to learn through errors, problem solving and skill rehearsal[125, 239] and relate them to real-life practice (M)[195]. Professional self-efficacy will likely increase (M), enabling OMGs to feel more able to apply new knowledge and skills in practice (O)[191, 239] (CS1-3). They will acquire new resources that can be used in what are potentially stressful situations (M), causing them to feel more prepared to meet the demands of practice (O)[191, 212, 235]. Those interventions lacking experiential learning noted its absence as a flaw (CS6, 10, 12). Feedback and reflection on performance will lead to increased self-awareness (M)[125, 186, 196] (illustrated in Figure 10). Once OMGs take responsibility for their own learning[85], this may enhance motivation to learn (M) and continued professional development (O)[85] (wright (maintaining strengths and improving less effective practice). Overall work and interaction adjustment[233] are likely to result from these necessary processes (O).

Observational learning is another way in which OMGs can learn. Through giving feedback to peers and asking questions (C)[91, 168, 189, 191, 194, 200, 203, 206, 207, 211, 214, 230, 237, 241, 252] (CS3, 4), knowledge and understanding will likely increase (M).

Case study 2 - Observation

For some OMGs attending POD, there was a change in perception of their own abilities, what they deemed successful communication skills to be, and understanding of the doctor-patient relationship (m). The individual rated themselves very high in the pre-intervention questionnaires, explaining some initial resistance to the intervention. However when individuals were shown what skills were expected and given the chance to practice (c), they become more self-aware (m). This was illustrated through a decrease in perceived competency scores (evidenced by self-assessed questionnaire) following POD (m). Self-awareness was also addressed through continual feedback and reflection (c). One individual seemed genuinely unaware of what was expected of them beforehand. Therefore, since acquiring the knowledge and awareness of good practice, they recognised the need to develop their skills further, the intervention altering unrealistic self-perceptions (m). The individual's self-efficacy also decreased slightly following the intervention (again, illustrated through questionnaire) as they recognised the need to develop further skills to ensure good practice (m); perhaps also being more self-critical as a result of feedback and a new way of learning (m).

Figure 10. Illustration of increased transformative learning and self-efficacy following a two-day intervention for OMGs (CS2)

However, educators must be aware of differences in how OMG learn and learner responsiveness (C)[189, 216, 227], which can hinder learning[202]. The focus on self-assessment, self-directed learning and professional development are likely to be effected by cultural variations[201, 239]. Feedback and reflection will also likely be a novel way of learning for some. Differing cultures view feedback in different lights, those from more hierarchical cultures often seeing feedback as a way to publicly shame and embarrass for lacking competence[253]. These individuals may experience levels of anxiety and not feel able to participate (CS3) (M)[185], not wanting to expose and discuss difficulties[96, 181, 205, 212, 232]. Those from collectivist cultures may appear less assertive and less engaging than host country graduates both in the classroom and on the ward (CS3). Complex experiential knowledge is not readily accessible through traditional learning methods such as exam prep courses and books, most often used by OMGs. Some individuals may want to be told how to do something, rather than through problem based learning[227]. These factors can impact upon the dynamics of group teaching.

Varying teaching methods should therefore be implemented to help overcome differences in how OMGs learn (styles), noted within a number of studies (C)[85, 185, 195, 206, 228] (CS1-3, 4, 7), [89, 102, 115, 125, 158, 186, 193, 196, 198, 204, 207, 214, 219, 220, 226, 229, 235, 240, 241, 244]. Methods were most successful when appropriate feedback was given, helping to guide OMGs through the process (C) and remove barriers to learning in a new cultural context (evidenced in Figure 10) (M)[2, 88, 91, 125, 178, 179, 181, 193, 194, 196, 204, 206, 211, 212, 214, 215, 220, 223, 225, 227, 235, 247, 250, 252] (CS1, 4). Feedback should be relevant, immediate, direct, detailed, constructive, structured and from multiple sources where possible[125, 158, 211, 230, 251]. Feedback can be both formal and informal. Many of the factors discussed at the individual level, such as capacity to change and preparedness for practice, can impact upon acceptance or ability to utilise feedback (M). Medical educators must therefore understand the anxieties that learners may have, fostering a learning culture that values feedback as part of professional development (C). Expectations around feedback and self-reflection must be asserted, ensuring that all involved have the necessary skills; including OMGs, educators and supervisors. Educators should feel confident enough to be critical of performance and not avoid issues that may be perceived as discriminatory, such as communication and culture.

Where one day interventions are implemented through didactic teaching methods (CS10), they are unlikely to address such issues discussed above and ignore the differing learning preferences that may be within the group.

Role-modelling:

The inclusion of role-modelling was seen as important for OMGs[54, 83, 91, 102, 165, 185, 194, 199, 201, 206, 207, 210, 227, 228, 230, 232, 234-237, 239] (CS4, 6, 7, 9, 10), as it enabled them to relate to those who have faced similar issues (C)[99, 219]. Hearing the stories of OMGs who have been through a similar transition will raise awareness that issues faced are 'universal', reducing anxiety and increasing Cultural Health Capital (M)[197]. Seeing others succeed may also increase self-efficacy and engagement with training (M)[99, 204, 239] (CS4), leading to work adjustment (O).

Intervention design & content:

Interventions were deemed most successful when the programme content reflected issues of concern to the OMGs attending[14, 54, 85, 98, 125, 158, 179, 185, 186, 189, 194, 196, 197, 199, 201, 203-208, 211, 214, 216, 217, 220, 223, 224, 226-230, 239, 241, 247, 254] (CS1-7, 9, 13, 14). As discussed previously, being learner focused and meeting individual needs was important (C)[14, 216] (CS2, 3, 10). OMGs are more likely to engage with the content (M) if relevance and a rationale for learning are identified. This will then lead to increased knowledge, skills and understanding (M)[85, 89, 178, 181, 186, 189, 190,

[192, 194, 196, 203-206, 216, 217, 224, 227, 230, 233], in areas such as communication and language, professionalism, cultural awareness and development of clinical and organisational workplace competence (O). Self-efficacy will increase as understanding, experience, and perceived performance increases (M)[216, 224].

The importance of OMG goals and expectations of interventions prior to participation was also noted (C)[54, 88, 179, 194, 205, 207, 211, 215, 218-220, 223, 229, 235, 240, 251] (CS1-3, 7, 14), information sent prior to arrival helping to overcome such issues by explicitly stating intervention aims[201]. If expectations are not met, engagement will likely decrease (M)[185] (CS14). The learner should also be actively involved in the development of learning goals to ensure they meet the expectations of both themselves and the organisation (O)[197]. Interventions should not be built purely on deficiencies in medical knowledge and communication[99, 219, 227] (CS11), but should include the professional role[66] and survival skills to enable future difficulties to be managed successfully[88, 233]60. Organisations often focus on clinical competence and ignore crucial learning needs.

Many of the studies reported that experienced and enthusiastic medical educators were recruited to deliver the training (C)[14, 54, 88, 99, 125, 158, 185, 186, 189, 192, 196, 201, 204, 211, 214, 220, 226, 227, 229, 232, 233, 235, 239, 244, 247] (CS1-3, 7, 14), ensuring an understanding of OMG learning preferences and cultural sensitivity of differing needs[99, 219] (CS7). This expert knowledge and commitment to the training ensured interventions were successfully implemented and OMGs were engaged (M). It is noted however that experts may not be readily available[190]; illustrating issues of scalability and transferability.

4.5.3.4 Contextual factors of training: external to implementation of intervention

Ongoing support (training, peer and supervisory):

Ongoing support was found to be central to OMGs' transition (C)[14, 54, 66, 73, 83, 91, 102, 158, 165, 178, 187, 188, 190, 192, 195-197, 199, 200, 203, 207, 210-212, 215, 216, 220, 222, 224, 225, 227-229, 231, 232, 234-239, 244, 252] (CS7, 9, 11), helping them to manage stress (M) and adjust in a healthy manner (O)[2]. High levels of support at an early stage[188, 199] would be most beneficial as they will help identify any initial problems and prevent escalation (C)[99]. However, the monitoring of progress after an induction programme[99, 218] is needed to ensure transformative learning and transfer of learning (M)[186], impacting upon overall fitness to practice (O)[178, 239].

Ongoing training, such as follow up sessions, or the implementation of training spread across a number of weeks, was found to be beneficial[99, 201] (CS7). However, issues with engagement arose in one case study (CS6). Ongoing support was also limited due to lack of resources[189, 251]. When ongoing support is not offered following training, OMGs may feel unable to ask for support due to fear of being seen as incompetent or due to lack of time[234]. One OMG reported 'Everyone was too busy. We had to get on with the work, but I didn't learn properly' (p.583)[195], highlighting the negative impact on learning (M). Figure 11 highlights an example from an included case study.

Implementing a buddying or mentor scheme was highlighted as an effective way to provide ongoing support, both professionally and socially[66] (C). Buddying can help to enhance the efficiency of an initial training programme[2, 201, 209, 224, 226, 237, 239] without being costly[99, 187]. The needs of the individual will determine whether they will benefit from a host country buddy[209] (CS2, 3) or an OMG buddy[66, 210] (CS9). Both were reported to have advantages and disadvantages for social capital (involving social interaction, trust and shared vision), offering different types of support for 'bridging' and 'bonding' capital (M). Whilst a host country graduate will have necessary work, language and cultural knowledge, aiding in all levels of adjustment, those from a similar culture can perhaps aid in terms of providing 'inside' knowledge and coping strategies[210]. Being able to relate to an individual that has experienced similar difficulties will not only mean acquiring resources quicker[237], but increasing overall Cultural Health Capital[2]. Having a personal buddy of any kind can provide information when necessary (C) will reduce stress and anxiety and support Cultural Health Capital (M)[165, 197, 254]. An increase in self-efficacy is likely to result from this support (M)[188, 197, 239] (CS2), this confidence ultimately being applied in the learning environment (O)[224]. Retention is also more likely, with the ability to adapt to and master new skills (O)[158, 239].

Research reported that relationships should be informal and not forced[91, 165, 188, 236, 237], requiring an empathetic figure who can guide OMGs to self-monitor and re-examine their ideas and adopt cultural norms (C); leading to increased self-awareness and professional/personal growth (M)[237] (transformative learning). OMGs may then begin to enjoy the process of change, making them more likely to engage in other learning opportunities (M). A buddy should also be engaging, committed to the relationship, approachable and have received the necessary cultural awareness training needed to take on the role (C)[188]. A poor understanding of cultural differences can cause distress (M) and therefore have a negative impact on both work and interaction adjustment (O)[2]. The success

of the buddying requires the pair to be matched[210] and work in close proximity so that stronger relationships can be established (C)[91, 234, 236]. Buddying was reported to fail in some cases due to a lack of facilitation and commitment in its initial implementation (C) (CS3, 6). A buddy can also support cultural adjustment outside of work (O)[2, 98, 236].

Case study 14 - Observation

The individual was motivated to learn and the organisation was supportive in terms of training (c); evidenced by the individuals attendance at the communication skills training. However, the individual stated that peers and supervisors were unsupportive in practice (c). This led to a lack of self-efficacy and feelings of stress (m). The individual would not ask questions in practice, further reducing Cultural Health Capital (m) and hindering professional growth (o). Not asking questions also led to patient safety issues, the individual performing procedures without knowing how to do so (o). Perceived barriers and feeling of loss through poor treatment (c) led to feelings of low self-esteem and self-worth (m). It was perceived by the OMG that this may explain why other OMGs have returned home (o).

The lack of support (c) is likely to have led to this reduced self-efficacy, feeling of loss, and increase in stress, as they felt unable to ask questions or find necessary resources (m). This impacted on their performance in the workplace and increased the chances they will return home (o).

Figure 11. Explanation of why one individual from case study 14 reported transition struggle

Supervisors were identified as key to providing ongoing support and regular feedback (C)[14, 73, 85, 88, 91, 98, 158, 186, 189, 195, 197, 201, 203, 205, 211, 214, 218, 222-224, 230-232, 235, 239, 252]. Supervisors should be involved with both the implementation of the intervention and individual needs assessment[158] aiding transformative learning (M) and providing a platform for continued professional development (O)[218, 224, 237] (CS9). The quality of supervision is important, as OMGs often require more support than host country graduates[14, 91, 211, 214] which can be time consuming[189, 224] (CS1-3). Supervision can be challenging due to the often short duration of posts[91]. Supervisors therefore need to have the appropriate training to ensure they have the necessary skills and cultural awareness to support OMGs[230] (C). This level of support will likely further reduce anxiety and stress (M).

Peer support in practice was also found to be essential to ensure the necessary support is available[158, 187, 188, 194, 196, 201, 205, 210, 214, 216, 224, 235, 236, 247]. It is noted that there is often a lack of support and cultural awareness amongst colleagues[215, 222, 232, 233] (CS6, 14), which may lead to a risk of stereotyping, prejudice and discrimination (C)[195, 207, 209, 213] (CS14). Where there are perceptions of hostility, this can hinder acquiring social capital and lead to stress, anxiety,

feelings of exclusion and poor Cultural Health Capital (M)[195, 215]. This impact upon resilience in overcoming difficulties[215, 233] will hinder both performance and retention of knowledge (O)[209]. For example, if there is no support from supervisors or peers, OMGs may feel unable to apply the skills they learned within the training, such as communicating with colleagues, so will not ask questions if they are unsure in practice; a risk for patients (O)[209] (see Figure 11 for an example of this).

Colleagues must understand both equality and diversity and feel able to give feedback to OMGs without the fear of being perceived as discriminatory. Where colleagues illustrated empathy and support[179], and were appreciative of past experiences (C), social capital was much more likely to increase, impacting intercultural communications and Cultural Health Capital (M)[165, 197, 215, 254]. This support was also likely to increase feelings of acceptance, empowerment and both personal and professional self-efficacy (M)[197, 212, 215, 224, 234, 239] (CS4). OMGs are more likely to engage with and transfer learning if there is a sense of acceptance from colleagues (O) (CS1)[195, 197, 209, 215]. This will have an impact on both professional development and performance (O)[195].

Supervised practice:

Opportunities to perform the learned skills in practice, with feedback (C), were thought to both reinforce learning, aid in behaviour change (transformative learning) and increase self-efficacy (M)[73, 186, 211, 233]. All team members need to be involved in supporting OMGs if they are to transfer what has been learned in the intervention and ultimately be prepared for practice (O). This opportunity for assessed practice was found to be particularly useful for those who have not practiced for a few years[85].

Support network (including social integration):

Support networks, consisting of both OMGs and host country graduates (C), were reported to lead to optimal social capital (M)[102, 247] (CS7,10). Silo social development hinders the ability to communicate with colleagues (O)[204, 215]. OMGs will benefit from learning through social interactions with all groups (C)[102, 187] which will increase self-efficacy and resolutions of personal conflicts and lead to expressions of feelings (M)[232]. As stated in one article; 'I learned to believe in myself' (p.247)[203]. However, where there are feelings of isolation and hostility from colleagues (C), there can be a dependence on those from the same culture (M) (CS6). A well-resourced work environment is needed (C)[102, 188]. This helps OMGs identify and connect with their network and has an impact upon transformative learning, particularly negotiation and awareness of differences (M)[102, 206, 219, 224, 232]. This will in turn lead to greater

levels of professional development (O)[85, 102, 232]. Both OMGs and host country graduates will benefit from bridging social capital (M), creating access to new resources[102, 219] that will enable more positive behaviours within the workplace (both work and interaction adjustment) and increase retention (O)[187, 199].

These support networks were found to provide enriching social opportunities both inside and outside of work (C)[14, 85, 102, 236]. Facilitation of interactions between OMGs, their families, other staff members, and local communities was reported[54, 73, 187, 188, 194, 207, 208, 213, 217, 236-238, 247] (CS4). It was felt that feelings of isolation and alienation are detrimental to wellbeing (M)[2] and therefore overall transition (O)[98, 215].

However, such social networks can be hard to establish when there is a lack of continuity, for example if OMGs were moving between hospitals (C)[223]. In such circumstances building Cultural Health Capital and engagement with teams can be hard (M). Those in postgraduate training positions were more likely to have a stronger support network around them[2].

4.5.3.5 Contextual factors of the individual

Capacity to change:

Commitment to change was identified as being necessary[217], OMGs having to participate in and understand the need for the intervention (C)[2, 54, 89, 125, 158, 165, 181, 188, 195, 198, 201, 206, 213, 216, 224, 229, 234, 235, 237, 239] (CS1-4, 6, 12) if transformative learning is to take place (M). If OMGs are not accepting of the new culture (C)[209], bridging of differences between the two cultures (M)[215] and overall work adjustment (O) will not take place. Subjective differences in culture, such as values or communication style, are more difficult to recognise than objective differences, such as food or clothing. OMGs may be more readily able to accept the latter[238]. Interaction adjustment will also be hindered (O) through incapacity to change (C), OMGs not asking questions when they do not understand, or participating in group discussions (M)[211, 212, 244].

Holding an unrealistic self-image was also found to have an impact on capacity to change (C)[24, 89, 102, 179, 181, 188, 204, 211, 218, 227, 232, 233, 247] (CS2, 12). This lack of self-awareness is likely to result in reduced motivation to learn (M)[205, 220, 221, 228], for example wanting to complete the programme in the shortest possible time[195], or resistance to feedback (M)[202]. Many OMGs focus on acquiring medical skills and knowledge and so fail to see the need for other training[219, 220], which will ultimately impact on their professional development (O)[208, 237]. Without this self-monitoring (C), insight into learning needs and professional growth will likely be hindered (M)[91, 208]. OMGs must be motivated to continue to adapt and reflect on

their performance when in practice[42, 223, 246]. It was noted that OMGs sometimes focus on positive feedback and minimise areas needing improvement[211, 255], however this may be due to individual differences as discussed earlier. Unrealistic self-image may be the result of a lack of cultural awareness (C)[98], resulting in misidentified needs (M)[216, 219]. Figure 11 illustrates how such issues were addressed by the intervention (O).

Incentives and expectations:

Incentives for OMGs to participate in interventions (C) were found to have an impact upon motivation to learn (M) and transfer into practice (O)[83, 102, 185, 192, 196, 198, 200, 203, 205, 214, 215, 218, 219, 223, 224, 226, 229, 233, 235, 237, 239, 244] (CS2-4, 7, 11). An individual motivated by the outcome of exams (C) may focus heavily on this[14, 85, 158, 217, 251] (CS9) and be less motivated to improve practice (M)[204, 224]. Assessment is ultimately likely to inhibit learning, and therefore performance (O). If OMGs participate when attendance is voluntary (CS3, 5, 6, 14) or there is a fee requirement (C)[158] (CS11), their motivation to learn is likely to be high (M), whereas mandatory attendance or not requiring a fee (C) (CS1-3, 12) may produce a less motivated group (M). However, if there is a lack of insight into the new ways of practising or if OMGs do not have the self-awareness to assess their own needs, individuals will not participate voluntarily (C) (CS2) and transformative learning will not occur (M). Without incentives, individuals may be less motivated to learn (M) and more susceptible to drop out (O)[224]. As discussed at the organisational level, where high commitment and support is demonstrated by the organisation, the incentive to learn is also likely to increase (M)[14, 225, 241].

OMGs often make real sacrifices to take up job opportunities in another country, either leaving family behind or uprooting them (CS1-3, 6, 14); therefore, they are likely to arrive highly motivated. However, this motivation may not last if OMGs arrive with unrealistic expectations and goals[214] with regard to quality of life, work experiences and their future employment opportunities (C)[85, 205]. OMGs must arrive aware of cultural and organisational expectations[89, 201, 203, 204, 213, 224, 225, 229] (CS1-4, 6, 9, 10, 14), otherwise they are likely to face culture shocks that will hinder the acculturation process (M)[209] and overall work adjustment (particularly performance and retention) (O). Training and support interventions can therefore aid in explaining the expectations of both the organisation and the culture, and in developing realistic career goals (C)[85, 216] and highlighting any potential barriers to practice (M)[205]. OMGs may experience changes in self-esteem, related to these unrealistic aspirations and the discrepancy with achievement (M)[51], which will affect their professional development within the organisation (O).

Role identity:

Unrealistic expectations were also stated to be linked to role identity[89, 165, 188, 205, 211, 222-224, 228, 229, 231, 232, 238, 239, 252] (CS2, 6); for example, if OMGs arrive and have to take up posts that are a lower grade than expected or a different specialty[232]. The job role in comparison to their previous role may be lower in status and power[195, 201, 213, 214] perhaps resulting in personal, cultural and professional loss of status and identity (C)[200]. Taking up the role of learner[201, 214] may impact self-efficacy[201] due to perceptions that they are unable to use their current skills[91, 195] must deskill or 'unlearn' their old ways, and conform to practice[73] (M). Younger individuals, new to training posts, may find it easier to adjust to a new system and acquire a good social network, likely to be more willing and flexible[51].

OMGs have reported feeling unappreciated, targets of racism, and being seen as a 'group'[224] rather than individuals (C), further hindering self-efficacy (C). OMGs have also reported that their qualifications are not recognised by their peers or employer (C)[229, 232]. If this is the case, motivation to learn is likely to be low and resistance high (M)[213]. OMGs must be supported to maintain a positive self-image[224] and seek to establish themselves in their new social and learning environments (C), which are likely to be different to what they are used to. Combining both old and new skills[195] will reframe their professional identity and enable them to modify practice (M) and take control, leading to professional growth and cultural adjustment (O)[200, 213]. Maintaining a positive self-image[213, 215] can be challenging if OMGs perceive they need to prove themselves (C)[201, 218, 221] (CS2), their levels of self-esteem and self-worth being affected (M)[219, 229], and as a result may hinder adjustment to working in this new environment (O). Pressures and expectations from home (C) can also add to lowered self-esteem and feeling of loss (M).

A loss of social networks can also hinder the formation of their identity within the new culture and organisation (C)[219], a lack of immersion within the dominant culture being found to lead to poorer mental health (M)[2]. Support at the training level is essential to aid in the formation of cognitive, affective and behavioural responses to culturally embedded practice[209, 216]. As discussed at the training level, the feeling of not belonging, as well as not wanting to appear incompetent or weak by admitting difficulties (C)[61, 218], may lead to increased anxiety[165] and communication barriers (M), which will hinder interactions with colleagues (O)[73]. Such changes in lifestyle and loss of social support can be demoralising for OMGs.

Preparedness for practice:

It was acknowledged that OMGs will have varying levels of clinical knowledge and years of experience and have been more used to didactic teaching)[73, 85, 89, 102, 125, 178, 185, 186, 191, 193, 200, 205, 209, 211, 212, 214, 216, 218, 222-225, 227-229, 232, 233, 235] (CS1-4, 7, 11). A lack of clinical knowledge and competence[14, 204] is likely to hinder interventions for OMGs as their learning focus may shift to the identified gaps (C), rather than the less clinical learning outcomes during the intervention (such as communication) (M)[73] (CS2, 3). Educators will also expect a certain level of competence from OMGs[194].

Differences in previous practice must also be acknowledged (C), an initial reluctance to question seniors or share views during ward discussions, in fear of being seen as incompetent, perhaps hindering transformative learning (M) and overall practice (O)[195]. Some individuals may feel unprepared due to not practicing for a long period of time (C), perhaps due to the length of time it has taken them to get registration and employment in the host country. Those taking up posts which are not in their specialty will also likely have gaps in knowledge of the new specialty[194]. Due to these differences, there may be individuals seen as more 'at risk' than others[226], perhaps benefiting from a longer interventions[158]. Yet others may feel prepared for practice due to their experience, either in their home or in the host country (C). Those more prepared for practice may be more resistant to interventions, due to a lack of motivation to learn and insight (M)[227]. Different specialties also have different learning needs, therefore a lack of specialty expertise may hinder the training as it will reduce its relevance. A needs assessment for all OMGs may overcome these issues (training level), allowing educators to understand more about previous experiences and knowledge gaps (C).

Differing levels of language and communication ability may also impact on learning (C). Language barriers may lead to difficulties in acculturation (M)[189], and ultimately will likely impact on work and interaction adjustment (O). Some OMGs may also feel unable to ask for clarification when they have not understood something due to a lack of self-esteem and confidence in their language skills[215, 219] hindering adjustment further (O).

Individual differences:

Individual differences were identified as facilitating factors in OMG transition[2, 54, 98, 102, 158, 188, 195, 199, 201, 206, 213, 214, 220, 227, 235, 236] (CS1-4, 6, 12). The acculturative process was found to be mediated by individual factors such as age, gender, ethnicity, culture and personality[73, 188, 189, 197, 251, 256]. For example, female OMGs, who often have differing needs to men, may need different support (C). 'Home' gender roles and gender role expectations may be in conflict

with those in the new culture (M)[256]. However, women have been reported to experience fewer feelings of isolation and higher levels of engagement (M)[197]. Transition is likely to be influenced by the personality of the individual and how resilient they are (C), culture shock being experienced by some individuals but not others (M)[188]. Culture shock has been linked to poor mental health (O)[85], impacting on acculturation (M) and creating a barrier to practice (O)[205]. Individual differences may also limit the emotional support offered by educators because of a fear of violating gender or cultural boundaries[233]. The differences between those from international and European countries must also be recognised (CS1- 3); for example, attitudes to mistakes and feedback mentioned previously (M)[250].

Differences in individual circumstances were also found to have an impact on adjustment[54, 73, 85, 200, 209, 211, 228] (CS1-4); for example, the nature of migration, barriers faced in gaining employment and length of time living in the host country (C)[252]. The process of migration itself may be stressful (M), both practical issues and lack of a social network impacting on this (C)[51, 224]. For example, if the individual has a spouse that has moved with him or her, or family and friends already living in the host country[252] (CS2, 6), he or she may be able to adjust more quickly (O). Cultural Health Capital (M) is particularly likely to increase if those individuals have been, or are, working as a health professional in the host country themselves (CS3). However, acculturation can also be hindered by family issues, such as spouses or children finding it difficult to adjust[219]. OMGs who arrive may also face external pressures from family back home to succeed (C)[209, 246], likely increasing stress (M) further. Stress and anxiety are also likely to be higher (M) when individuals have had very little time to adjust prior to beginning work[98], often having to start work within a week of moving to the host country. This means less opportunity to adjust to the new training environment or build a support network (C). Social, financial and personal resources will also differ for each individual, reflecting in the acculturation process (O).

Perceived barriers:

It was acknowledged that OMGs may feel that the system for working in another host country is unfair, particularly where barriers make entering the system and career progression difficult[85, 224, 225, 232]. Interventions for overseas graduates may therefore be seen as another hurdle that they have to clear (C)[73], perhaps decreasing motivation to learn (M). Being told that extra training is needed can have an impact on self-efficacy and self-esteem (M)[205, 215], particularly where high positions had previously been held, and ultimately impact work adjustment (O). These feelings of stigma, as discussed at the organisational level, may also hinder capacity to change (C)[213], OMGs feeling they have to prove themselves as being

equal to host country graduates. Barriers may also be perceived following training interventions, for example, a sense of being unnecessarily questioned in practice (C) will act as a threat to the sense of self (M)[213]. OMGs may then feel they cannot admit to mistakes and may not ask questions if they do not understand[229].

4.6 Discussion

4.6.1 Summary of findings

This synthesis has investigated interventions designed to aid the transition of OMGs to health care organisations, specifically looking at contextual factors that will mediate mechanisms that are likely to lead to a successful transition (Figure 9). The findings very much support the initial middle-range theories presented in the previous chapter, this realist synthesis leading to refinement and expansion of the middle-range theories that were first proposed. Findings were organised into the same three contextual levels; individual, training and organisational – as were initially developed.

Successful interventions seem to be those that not only offer a developed intervention, targeting individual needs of the OMGs within a supportive environment[14, 158, 185, 192, 209, 216, 217], but offer ongoing support from both peers and supervisors during and following implementation[143, 209, 211, 214, 215, 218, 224, 233, 237]. In line with the initial theory presented[128, 158] the importance of experiential learning and role-modeling is also asserted[73, 99, 125, 186, 204, 211, 233, 239]. These factors are key in prompting OMGs to engage in transformative learning, increase their self-efficacy and Cultural Health Capital, and reduce feelings of stress and anxiety[102, 194, 206, 216, 219, 224, 232]. Where cultural awareness and support of the organisation are evident, interventions are likely to be more successful, with increased engagement, motivation and commitment from OMGs[143, 145, 158, 185, 192, 209, 217]. However, if the organisational level is working alone, for example successfully implementing training (thus has resources and leadership), but offers no other support outside of this, it may not lead to true change in culture[195]. Instead it may act as more of a 'welcome'. Interventions will be most effective for those individuals who have the capacity to change, motivation to learn and feel able to maintain their role identity[200, 201, 204, 213, 217, 224]. Kirwan & Birchall place a great deal of emphasis on motivation to learn at the individual level, however current findings extend beyond this factor and explore other influences at the individual level[145]. Organisations have to understand that OMGs will be making their transition with differing levels of preparedness, and individual differences[14, 56, 73, 188, 189, 195, 197, 204, 251, 256]. Organisations

must aid OMGs with their loss of natural support networks, feelings of isolation and pressure to take on a new culture[2, 98, 215, 219].

As the 'cogs' illustrate in Figure 12, the findings support the initial theory suggesting that most efficient transition process will occur if all levels are operating effectively[145].

CMOs highlighted by Gerrish & Griffith (2004)

The organisational culture was one that valued diversity and equality of opportunities (c). Despite being resource intensive, the need for the adaption programme was recognised (c). The programme was well developed and offered ongoing support through supervised practice and a mentor (c). Despite a perceived lack of supervisor time (c); causing them to not 'learn properly', and feeling 'unappreciated' and different, the overall ongoing support overcame any potential issues here. Individual incentives for participation were initially focussed on exam success, a loss of status motivating them to gain registration as soon as possible (c). However, through the developed programme and ongoing support, the overseas graduates recognised that they have other needs that have to be addressed in order to be fit for practice (m). This support also led to greater feelings of 'self-efficacy' as they perceived themselves to be a valued part of the team (m). As a result, successful outcomes included registration, fitness for practice and increased retention rates (o).

This example illustrates the interaction of the three contextual levels. The organisational culture and level of support, not only leads to increased confidence and commitment from the overseas graduate themselves (m), but feeds into the development of the programme and ongoing support offered at the training level (c). Where contextual issues arise that may hinder adjustment, such as individual incentives, perceived underlying racism or strain on resources, the ongoing support at the training level enables the necessary mechanisms to be triggered (self-efficacy and transformative learning) which in turn may lead to registration, fitness for practice and retention (o).

Figure 12. Use of theory to explain why Gerrish & Griffith[195] reported successful intervention outcomes

Although adjustment will take place at the individual level, inputs at the organisational and training levels are crucial to avoid resistance by the organisational and training level 'cogs' (see Figure 12 for an example). The complexity of issues at all levels must be understood in order to ensure transfer of learning into practice. As illustrated, many of the themes overlap.

4.6.2 Findings in context

The findings provide clear guidance on the most effective ways to support OMG transition, presenting the theoretical evidence that was lacking[53, 97, 102]. Many programme theories are evident within the literature, but authors do not always refer to them. This synthesis helps to shed light on relevant programme theories. Lineberry *et al* made the first attempt until now at reviewing educational interventions for OMGs[53]. This current piece of research is the

first realist synthesis to be conducted in the area. The detailed exploration of the current synthesis explores many of the questions left unanswered in the recent systematic review[53], particularly what interventions are likely to work and what level of support is appropriate. In line with findings from the systematic review, interventions for OMGs also varied in terms of length and scope[53]. Much needed theoretical explanations are given as to how interventions achieved their effects, not just drawing conclusions from empirical generalisations.

The systematic review by Lineberry *et al* also stated that in terms of desired adjustment outcomes, the focus should not only be on performance, but OMGs should also be more satisfied, better adjusted to life in general, and more committed to the employing organisation[53]. These factors were explored within the synthesis. The findings of this synthesis support the assertion that few studies have measured job satisfaction or socio-cultural adjustments, improvements in knowledge and skills being the primary focus. This is evident as the area of general adjustment had to be removed from the evidenced theory due to a lack of available data to support it. Focus of organisations was very much on work adjustment, hence further guidance is needed.

These current findings place a great amount of emphasis on the need for ongoing support throughout the transition period in order to increase both performance and retention, supporting previous recommendations in the literature[98, 153, 160]. Interventions should focus on ongoing 'transition', rather than 'orientation', in other words a single induction is unlikely to be enough to support the transition of OMGs, which is ongoing. This is particularly important since the case studies reported within the UK generally lacked this ongoing support. The building of a sense of community in the workplace, to cultivate social support networks[257], seems to be a key factor that will enable an efficient and overall successful transition (illustrated in Figure 12). This does of course depend largely on the level of organisational support and engagement with integration. Although programme content and delivery is also important, a feeling of being accepted emerged as one of the most significant issues for OMG transition[257]. Evidently, integration is more than simply a training programme[192], supporting the initial grand theory[143, 145]. No programme can cover all learning needs, therefore the surrounding environment must facilitate the transfer of learning and more importantly engage OMGs in new learning. Individual needs have also been a recurring theme throughout[74, 153]. Contextual factors at the individual level must be assessed to ensure needs are addressed, as these may hinder the adjustment process. Cultural awareness and support at the training level can facilitate this.

Insufficient evaluation of the included studies was also noted by the previous systematic review[53], again largely supported by my synthesis. Where a specific intervention was put into place, the targeted skills or behaviours were not always tested. Instead, self-assessment questionnaires or satisfaction surveys of the training were often used. This highlights a weakness in the current literature on OMG transition and the need for better evaluation processes. A more rigorous evaluation of the process, rather than a focus on outcomes, would be more beneficial. Insufficient intervention evaluation was also a reason why secondary searches and case studies were needed; to clarify the middle-range theories where evidence was lacking. Case studies relied on participant feedback, rather than performance. However, this allowed for exploration of mechanisms at play. Outcomes were explored through discussions with the relevant individuals.

4.6.3 Intervention recommendations

Essential recommendations are presented in Figure 13.

- An individual needs assessment is crucial prior to induction, taking into account individual differences and context of the healthcare organisation.
- Information concerning work, cultural and general issues should be sent to OMGs at the earliest opportunity.
- A rigorous and mandatory induction should be provided as early as possible before OMGs begin practice; content including communication skills, cultural awareness, and practical and ethical guidelines, with follow up sessions throughout the year ensuring reflective practice. The induction must be flexible to accommodate the identified needs.
- Those who are not in training posts should be given the same induction and level of support.
- Supervisors should be made aware of individual needs and give ongoing feedback to OMGs.
- Differing learning preferences (preferred format) and cultural experiences must be taken into consideration.
- Experiential learning opportunities are needed to ensure new practices are adopted and transferred into practice.
- A buddy should be trained and assigned upon arrival to provide ongoing support.
- Cultural awareness within the organisation must be evident.
- A robust HR process needs to be in place to ensure OMGs entering the organisation are identified.

Figure 13. Recommendations for implementing interventions for OMGs

Identification of the contextual factors presented will be primarily important for educators currently implementing or developing interventions. At a regional level, policy makers can use the findings to develop guidelines that health care organisations can use at a local level. Interventions are currently being implemented within some organisations, but if the necessary contextual factors are not embedded, the necessary mechanisms may not be triggered, so transitional outcomes (in terms of adjustment) may be hindered. It is also suggested that there should be opportunities for collaboration between institutes, which will further ensure more standardized and targeted interventions are in place. This may also lead to more quality, adaptable resources becoming widely available. It should be the responsibility of local and regional levels to ensure these issues are addressed, benefitting both OMGs and employers who have invested in their recruitment and/or training.

Providing a variety of safety nets, such as induction, buddying and enhanced supervision, is highlighted as being crucial for successful transition, supporting recommendations from earlier research[43]. There are more issues to address than merely lack of skills. The interventions would benefit from small group experiential learning, feedback and reflection, and making use of role-models. There is an obvious link between social and psychological processes at play in OMG transition, it being evident that if OMGs do not feel adjusted and do not feel part of the healthcare system, their professional and personal lives will be affected, and consequently, so may their delivery of healthcare. There is a high chance that OMGs may feel isolated, particularly at the beginning phase of their transition[2], therefore interventions must be in place upon arrival. One of the key strengths of a buddy scheme is that it requires little resources other than a dedicated coordinator and an individual that has the capacity to manage and support OMG needs.

Ultimately, organisations should not expect an easy transition and ignore potential difficulties, but must foster a supportive environment and understand the complexity of issues at the training and individual level. A smooth transition takes a minimum of one year[73] and resources are needed once OMGs begin work[196]. Stress is likely to be high for this group of doctors facing challenges both inside and outside of work. Dysfunctional adjustment may not only lead to poor job performance, but also result in OMGs resigning[3], which will have an impact on organisations.

Implementation at Trust level, rather than regional level, is suggested as it allows for the building of an ongoing support network. If implemented regionally, there will be less opportunity for initial support to carry on in practice. Other than providing information,

didactic lectures without opportunity for experiential learning are unlikely to have significant impact on practice. Perhaps over time, OMGs may adapt, but this may take much longer. In this time, performance is likely to be effected and retention may be hindered.

Therefore, individual Trusts should be encouraged to develop and pilot interventions, taking into account the recommendations given in Figure 13. Interventions should be developed based on individual needs, not making assumptions. The diversity of OMG needs is too great, as they are, all beginning work at different levels, different times, with different experiences, and from different cultures. Where resources are lacking, a minimum of induction specific to OMG needs and ongoing support should be in place.

4.6.4 Implications for the Programme for Overseas Doctors

This realist synthesis formed the foundation of the current research project seeking to implement and evaluate interventions targeting OMGs within the NHS. The findings from this synthesis fed into the development of the Programme for Overseas Doctors (POD) at Amity Hospital (AH). The next phase of the research involved testing the middle-range theory proposed in this synthesis through realistic evaluation of the developed intervention. Any issues found to hinder the transition of overseas-qualified doctors will be explored further. This will then lead to further development and suggestions for future interventions. The work currently being conducted by the GMC may benefit from this research.

AH benefitted a great deal from these findings (presented later in Chapter 6). Despite there being an enthusiastic leader driving for change, a lack of needs assessment meant that their initial made certain assumptions that all OMGs had the same needs. An expensive group of external language specialists and tutors were brought in to deliver intensive communication skills training, with a great deal of focus on language, however not all of the OMGs may have needed that high level of specific and intensive language training. Although very useful, it was costly. Communication skills in general, both with patients and colleagues, seem to be needed instead. Rather than trying to mould the individuals into talking a certain way and acting a certain way, they need to instead understand the culture and be self-aware of how they are performing within it. When asked about their needs, language was not always highlighted as an issue. Some focus on language is likely to be beneficial during inductions for OMGs, but communication should not be the entire focus.

A lack of ongoing support was also noted; therefore, a buddying programme was suggested. A more open culture where the doctors would feel able to ask questions, both on and off the

wards, was emphasised. As evidenced by the literature and case studies, the feeling of being supported and accepted may be the most crucial element of OMG transition, therefore may save unnecessary cost and resources in future programmes. This will be explored further within the next phase of evaluation.

4.6.5 Strengths and limitations of this realist synthesis

4.6.5.1 Strengths

The realist approach is emerging as a popular choice of methodology for understanding intervention effects in context[124]. It is an exciting, iterative approach, which involved the negotiation between stakeholders and researchers, adding more depth than the traditional systematic approach. It also required multiple types of information and evidence to be included, allowing for flexibility and inclusivity. As a result, a large number of context-mechanism-outcome patterns were drawn from the findings in order to build and refine the developed middle-range theory. The large amount of data across different contexts enables the theory to be more generalisable. The purpose of the case studies was to test this, also serving to build and refine emerging theory.

This synthesis has therefore begun to extend the knowledge base in the area of OMG transition, filling the gap that has previously been noted[53]. The synthesis does not offer particular lessons learned from best practice or a recommendation of the 'best' interventions for OMGs, but instead offers a set of tailored and transferable middle-range theories developed through a process of theory building. Knowing how interventions for OMGs work may prove more valuable than single recommendations in ensuring success. All of the interventions vary in terms of what they offer the OMG transition process; therefore, in synthesising the data, the researchers were able to see what elements are crucial to successful outcomes and make recommendations for best practice.

Although the theory was tested in primarily UK context, there is international relevance, in the same way that the synthesis has benefitted from international experiences in conducting the work. Findings highlight the vast differences in the ways interventions are being developed both within and between different countries. Therefore, it is suggested that a standardised set of guidelines is developed in each country, using recommendations made from this research, to ensure effective development and implementation of interventions.

The findings focus on context as the synthesis provides guidance for those implementing interventions for OMGs. Whilst the mechanisms are essential in understanding why and how

proposed interventions may work, offering a model that highlights the factors that organisations need to address and be aware of will hopefully aid ease of implementation. Identification of CMOs within the main body of text in this chapter (also presented in this way in the findings chapters) should also help to educate readers on the realist approach, the links being explicitly clear.

4.6.5.2 Limitations

One limitation of the synthesis was the lack of objective outcome measures within the literature. As discussed, many of the papers that reported outcomes were reliant on satisfaction surveys or self-assessments, which are known to be unreliable and problematic[74], or were purely descriptive. Small sample sizes were also common. Therefore, there was a lack of complete rigour in the conclusions drawn. The quality of some of the papers included in the realist synthesis may therefore be questioned. However, they were viewed as being contextually important to help piece the theory together. Realist guidelines assert the importance of this[124]. Perhaps if enough papers had been retrieved, only those with high rigour would have been included. Where outcomes were lacking, they were inferred. The use of secondary searches also helped to refine theory where it was lacking. Where outcomes were explored in a rigorous manner, studies often lacked the rich description needed to explore the theory in detail. The realist evaluation following this synthesis intends to aid in further refinement and development of a proposed programme theory.

Furthermore, the practical decision to limit the search to English written articles only, may limit findings to other non-English speaking countries. Limiting the search publications from 1990 onwards may also add to publication bias, however it was felt that due to the nature of the realist approach, this would not limit the findings.

An overlap between categories, particularly mechanisms and outcomes, arose on several occasions. This illustrates the subjective nature of the realist approach. Clear CMOcs were not always drawn from each source, making it difficult during the synthesising phase. The vast amount of CMOcs drawn from all sources complicated this further. However, discussions with experts in the realist methodology helped to overcome such issues. They were approached for advice throughout and asked to review some of the papers. Discussions also took place with a variety of other sources (supervisors, stakeholders, OMGs, trainers and medical educators were approached throughout). Having the initial middle-range theory to guide the process of data extraction and analysis further aided the process.

4.6.6 Conclusion

Designing interventions for OMGs is a complex task[74]. The synthesis included several interventions, such as specific skills training, orientation, buddying, peer support and web-based learning. Ongoing support is often lacking, particularly in UK interventions.

Systematic reviews rarely look at the underlying theories of interventions or explain the context, mechanisms and outcomes that will aid in future implementation[119]. The findings illustrate why interventions work (or not) and in what ways, thereby enabling those implementing interventions to make more informed choices that would benefit OMG transition. Contextual factors at three levels; organisational, training and individual, have been proposed, and the importance of their interactions highlighted. Organisations should not expect a quick or easy transition. They should ensure ongoing support and cultural awareness is adequate to support transition. Individual factors also need to be considered. Competencies were a focus of both interventions and evaluation in the literature[53] and therefore research needed to go beyond this and assess other aspects of adjustment (e.g. socially and psychologically).

4.7 Chapter summary

This realist synthesis aimed to refine the middle-range theories proposed in Chapter 3. The proposed middle-range theories were developed and presented in this chapter. The next phase of the research was to conduct a realist evaluation of POD at AH, which was developed following the findings of this synthesis. The intervention was novel in comparison to what was evident in the literature review of this chapter, incorporating many of the specific components suggested to support transition. The intervention therefore needed to be evaluated, further helping to develop an overarching programme theory. Exploration may help to answer some of the unanswered questions presented in this chapter, particularly the impact of specific aspects of the intervention, long-term outcomes and impact of individual differences. The findings of this research placed a great deal of importance on ongoing support, therefore it was important to explore the impact of this on overall transition, not just skills or performance. The next chapter will discuss the methods of the realist evaluation.

Chapter 5 Method - Realist evaluation

5.1 Outline

The previous chapters have explored the concept of realism and provided a rationale for using the realist approach within this project. The Transfer of Training model was identified as the grand theory that fed into the development of middle-range theories (Chapter 3). The theories were used to guide data collection during the realist synthesis (Chapter 4). The interpretation of the data very much supported the proposed middle-range theories.

A realist evaluation of the Programme for Overseas Doctors (POD) enabled testing and refinement of the middle-range theories using primary data. The aim was to develop a programme theory for POD. Findings from each stage of the research informed the development of the intervention (presented at the end of each set of findings in Chapters 7 and 8). The chapter beings by exploring the research approach and highlights ethical procedures taken. Data sources and data collection are then discussed (see Figure 14). Research methods included questionnaires, researcher observation, interviews and the exploration of performance (outcome) data. The analytical approach used is then presented. Justification will be given for the chosen techniques.

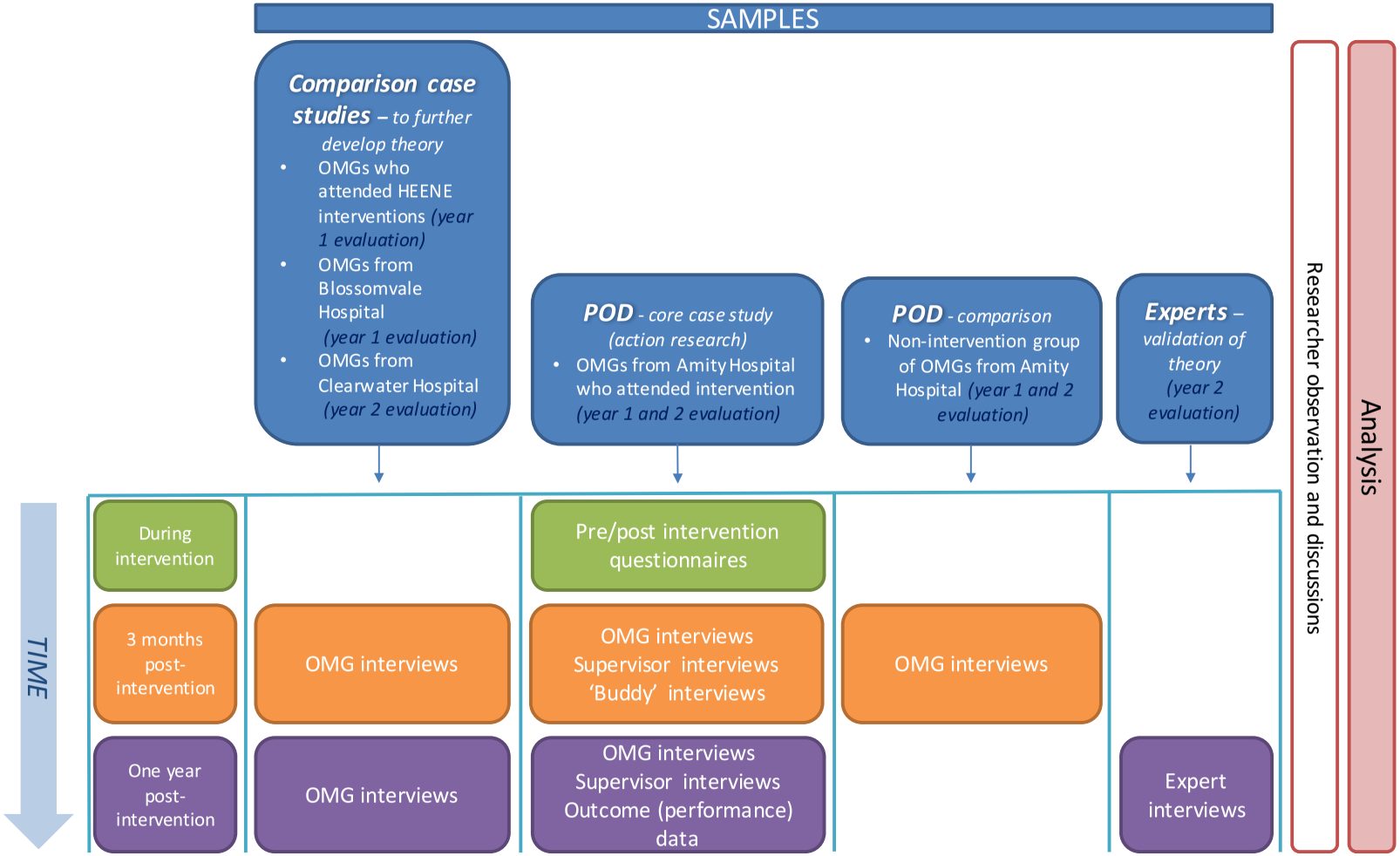


Figure 14. Diagram outlining participant samples and data collection methods

5.2 Realist evaluation of the Programme for Overseas Doctors

The middle-range theories developed during the realist synthesis were used to aid in an overall understanding of interventions for Overseas Medical Graduates (OMGs), highlighting implementation barriers and ensuring that necessary context factors were addressed. The intervention at Amity Hospital (AH) was developed following the findings of the realist synthesis in Chapter 4 (in which it was used as a case study and to refine theory). Engagement with stakeholders, policy makers and key decision-makers made the communication of key findings and conclusions easier. It was also important to explore the ideologies and social influences that were likely to have influenced intervention development[1]. The primary purpose of the synthesis was not to lead to an immediate change to the POD intervention (although this did happen) but to contribute to policy makers' and practitioners' 'sense-making'[1]. The approach helped to shift focus from successful performance outcomes to process evaluation and explanation. As a result, AH recognised the complexity of OMG transition and therefore supported the need for a realist evaluation. High quality evaluation of POD was essential for optimising its development, implementation and effectiveness.

Evaluation involving primary data collection was crucial following the development of middle-range theories. The findings from the realist synthesis highlighted the need for more robust outcome data and high quality evaluation of interventions for OMGs. Many hospitals have never tried, or have tried and failed, to implement any support intervention and therefore it was also important to understand what contextual factors may have led to this. Outcome-focused approaches would have fallen short in explaining how, and why, the intervention does or does not work. As Pawson states, evaluation is theory testing and interventions are 'theories' in themselves. This was also important considering that POD was made up of different components (different training programmes, buddying, peer support).

The realist approach can be both challenging and time-consuming in the context of a busy health service and explain why such theoretical understanding has been lacking in the literature[53]. Questionnaires are seen as quick and efficient. Most research also starts with a review of literature to pinpoint what is known and what is not known in order to provide a justification for new research. However, realist logic is quite different - realist synthesis (secondary data) followed by realist evaluation (primary data) provides a continuing test of the same theories with two different bodies of data. Given that OMGs will likely come to the UK with similar difficulties, the realist approach here intended to highlight patterns that

could be generalisable across care settings and which factors were particularly sensitive to local factors. Evidence was needed about the success of particular middle-range theories so that they could be used to generate a refined programme theory worthy of testing in the context of various other interventions[258]. Emerging outcomes needed to be tracked from specific mechanism and context configurations, particularly due to the lack of long-term transitional outcomes found in the literature. This is important since transition of OMGs is acknowledged as an ongoing process. The evaluation also sought to fill gaps left by the synthesis.

Ongoing support was central to POD, therefore long-term data collection was needed in this evaluation. As this was a novel approach to OMG interventions, ongoing support for OMGs lacking in the UK, robust evaluation was needed to see whether it was worth the investment of funding and resources. The findings from the synthesis also recommended that implementation at a Trust level, rather than regional level, was needed.

5.2.1 Aims and objectives

The theory-driven evaluation ensured that the overall research aims and objectives were met; explaining the contingencies as to how interventions support OMGs in making a successful transition to the UK workplace and highlighting barriers to a successful transition. The evaluation sought to explain change brought about by POD by referring to those individuals who act and change (or not) a situation under specific conditions and under the influence of external events (including the intervention itself). Exploration of the social reality that influences how the intervention is implemented and how actors respond to it (or not) was sought.

It allowed the generation of valid explanations as to why and how the observed results of POD were achieved (feeding into programme theory refinement), explaining the 'black box' that is often not addressed in outcome-focused approaches[116]. This was important in understanding how interventions could be developed and improved for future implementation.

Specific questions to be answered by the realist evaluation:

- Did POD effectively support the transition of OMGs to AH?
- What factors were vital to the success of POD at AH?
- How and why was POD effective (or not effective)?

- What barriers may hinder OMG transition and how can POD help to overcome these?
- What barriers hindered implementation of POD in other hospitals, despite the need being identified?
- What were the outcomes of not having adequate training and support interventions in place?
- What are the theoretical explanations that may be applicable?
- How can POD be developed and improved for future implementation?

5.3 Design

The overall project management came from myself and my supervision team. The design of the research was primarily guided by the types of data that were needed to answer my initial research questions, and more specifically, to test the initial middle-range theories. The design was also influenced by realist guidelines[124] and expectations of the funding Trust. Key drivers of POD at AH expected that the research would explore impact (outcomes), as well as explore theory (ultimately the context and mechanisms linked to these outcomes) to guide development and implementation of POD at each stage (see Figure 15). The evaluation intended to provide a framework to be used by those developing interventions for OMGs, not just the POD planning team at AH but regionally, when deciding practicalities and content of future interventions. These expectations fit with the realist approach.

A comparison case study design was adopted, including multiple comparison groups. This enabled in-depth exploration of the complexities involved in the single intervention, within its real-life context, and complemented the realist approach to evaluation[259]. Comparative groups allowed for further exploration of the emerging theory (detail of the included evaluation sites is given in Chapter 6). This design allowed data to be collected from multiple sources to explore the transition process through a variety of lenses.

The research design enabled exploration about what was important, what developed, and what improved between cohort (year) 1 and cohort (year) 2. The design had to be iterative to ensure refinement of theory took place. The prospective element enabled further exploration and refinement of the emerging theories as those involved were becoming more knowledgeable. Initial primary data collection was guided by the findings of the realist synthesis, the focus remaining on the three contextual levels; particularly organisational context and culture, ongoing support at the training level and individual differences.

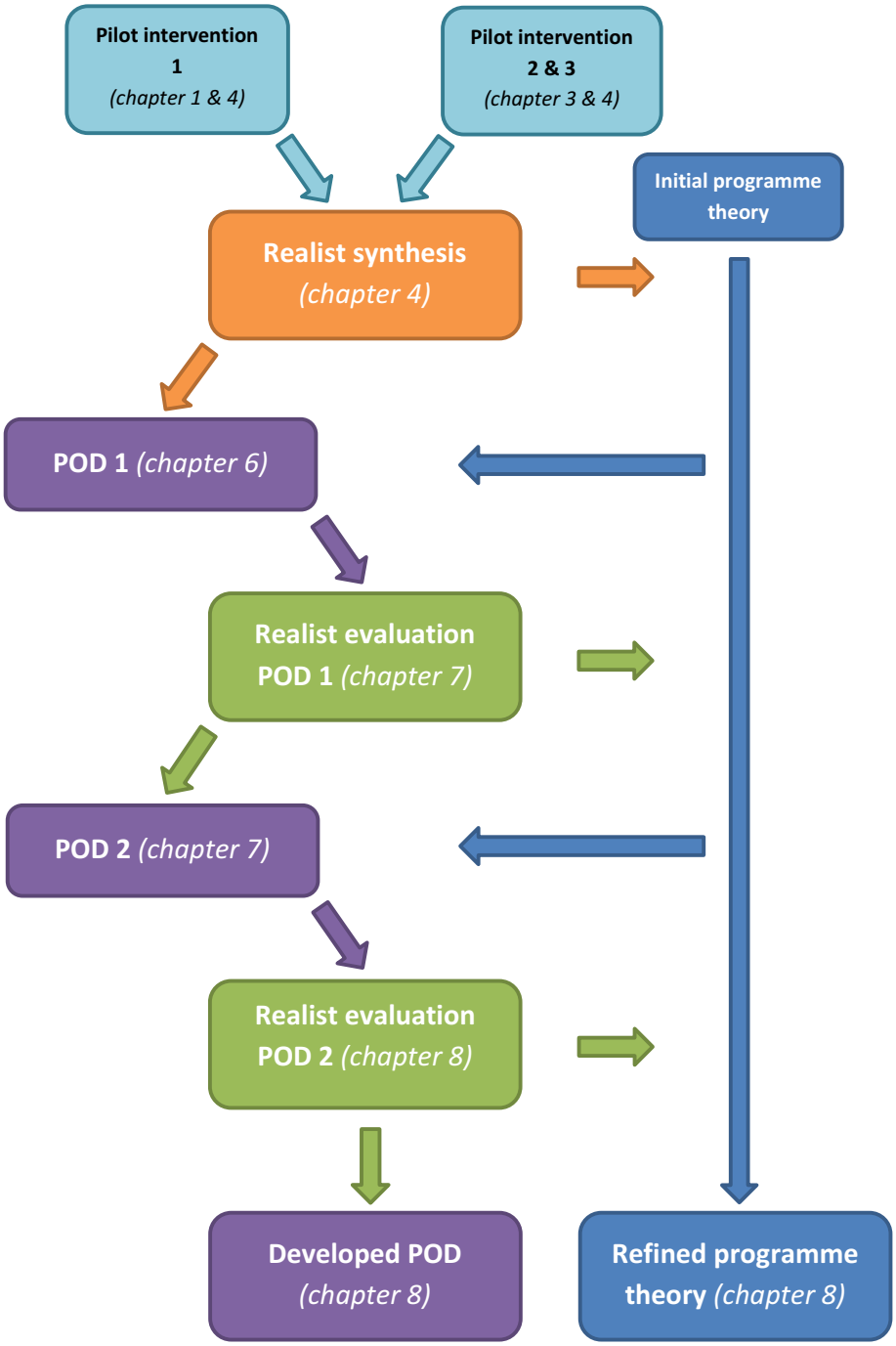


Figure 15. Overview of intervention development process

Due to both the initial purpose of the project and focus of the PhD, the intervention at AH (POD) was used as the primary case study in the evaluation. The evaluation took place over two years. Two cohorts of OMGs attended POD in this time (see Figure 16). The first cohort of OMGs received the intervention in September 2014. A refined version was implemented in August 2015 for the second cohort. Details of the interventions are presented in chapters 6, 7 and 8.

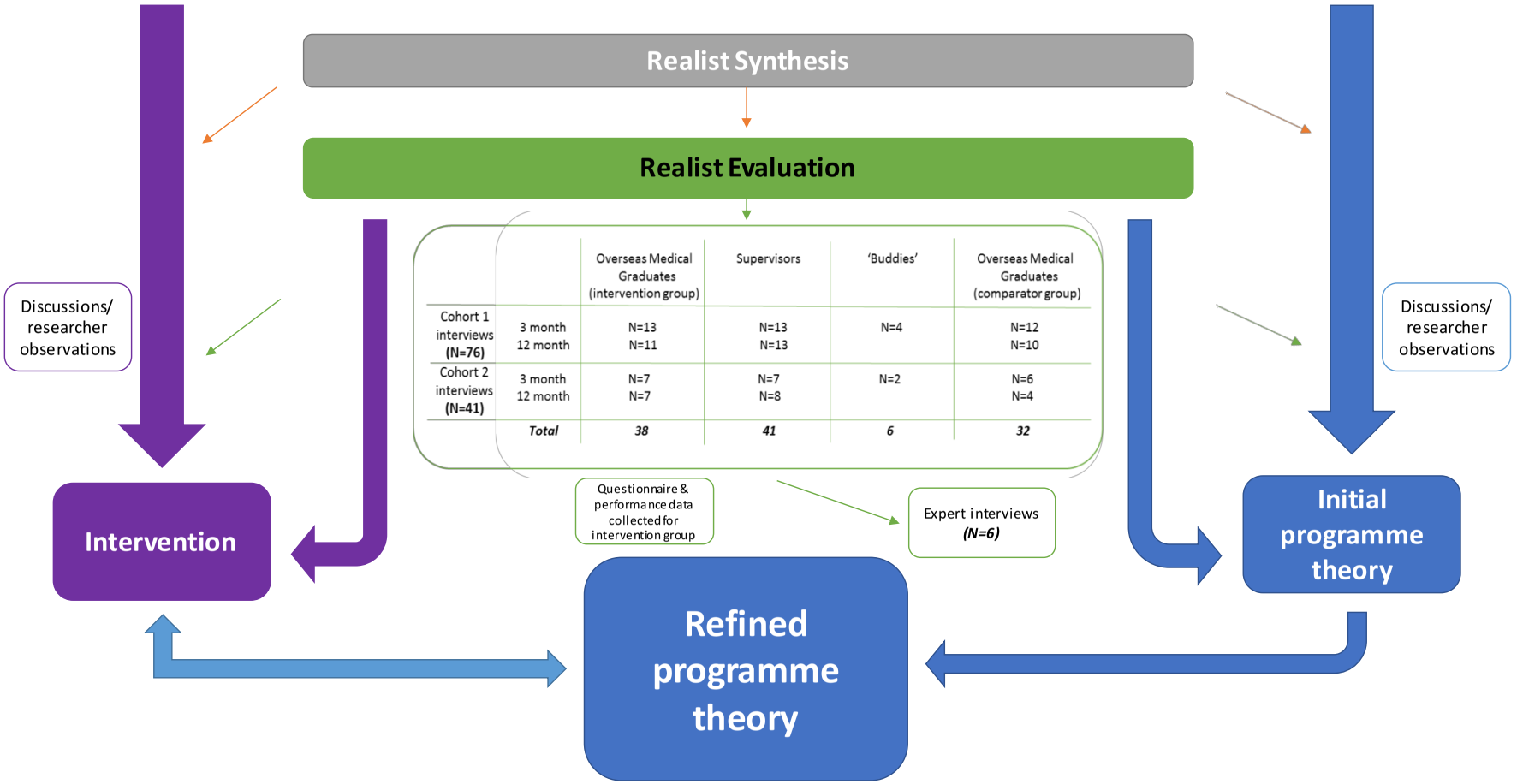


Figure 16. Overview of realist evaluation

Throughout this research there were no published guidelines from Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) specific to realist evaluation, unlike those used in the realist synthesis. Training materials were in the process of being developed to ensure quality and publication standards used in realist evaluation. This research was guided by published realist evaluations and the work of Pawson and Tilley[5, 116]. Reporting standards, very recently published, were used in the write up of the realist evaluation to ensure that the findings were accessible, helpful and usable[105].

5.3.1 Mixed methods

A mixture of methods to test all aspects of the programme theory (all CMOs) were used to conduct the evaluation. Mixed methods are the most commonly used approach in realist evaluation, making use of as many forms of data as possible[122]. The realist process of theory testing is often unpredictable, uncertain and unstable, substantial amounts of primary and secondary data being needed to explore explanations. Multi-method approaches ensure both triangulation of data at the analysis stage and embeds the realist framework experience[260]. It also ensures that theories are built up and refined, taking them from relevance to rigour[122]. As Emmel[109] states, all we have are fragments' and those fragments should be explored in-depth. Realists try to understand how each fragment of evidence contributes to their understanding and explanations; and how these are tested and refined within and between fragments. The focus of data collection was not on the person, but on the processes and events around them. Methods were chosen to complement each other and to fill different gaps in knowledge following the realist synthesis[261]; there not always being clear links or evidence. All chosen methods had a conceptual refinement function[5].

Mixed methods used in this research included; pre- and post-intervention questionnaires, researcher observations, interviews and exploration of performance data.

5.3.2 Overview of data collection

A brief summary of the data collected during the research is presented below. More detail is presented in later sections of this chapter, describing areas such as recruitment and methods.

5.3.2.1 POD (intervention) data

OMGs who attended POD completed both pre- and post- intervention questionnaires. They also took part in two interviews over a one-year period, along with their supervisors and 'buddies' ('buddy' roles are discussed in Chapter 6). Researcher observations and discussions

with key stakeholders from AH (director of medical education, postgraduate dean, intervention leads, trainers, other practitioners in the Trust, POD planning team) took place throughout the intervention. Performance data was collected from the Trust at the end of each cohort year (see section 5.7.4).

5.3.2.2 Comparison POD data

A comparison sample of OMGs from AH, who were unable to attend POD, were interviewed at the same two times as those who had attended POD.

5.3.2.3 Comparison data from other Trusts

Comparison samples of doctors from other North East Trusts were also interviewed at the same time. A direct comparison between hospitals, particularly performance outcomes, was unfeasible (due to resources and time-constraints of the PhD) and did not allow exploration of intended research aims. As with the POD data, discussions took place throughout with key stakeholders from other recruited Trusts. Each hospital illustrated different contextual factors that would likely impact on OMG transition (discussed in Chapter 6) and provided an opportunity to explore the developing theory within these contexts.

5.3.2.4 Expert data

A sample of 'experts' (implementers/stakeholders) were interviewed at the final stage of the project to validate the theory, after most of the data had been collected and analysed (sample discussed later). In line with the realist approach, these discussions took place with key stakeholders from a variety of organisations external to AH. Many informal discussions and meetings also took place throughout.

5.4 Ethical approval

Initial access to AH staff during the realist synthesis stage (May to July 2014) had been deemed by Durham University, School of Medicine, Pharmacy and Health Ethics Sub-Committee, as 'service evaluation'. This meant that ethical approval was not needed by the full Committee. The case studies included in the synthesis did not require ethical approval, as they did not involve data collection (only observations and discussions with stakeholders). However, the case studies provided an opportunity to pilot questionnaires that would be used in the full evaluation. Although not regarded as research, ethical permission from the Sub-Committee was granted in April 2014 so that this data could be collected (see Appendix 2).

Before conducting the main body of evaluation, full ethical approval was sought from Durham University, School of Medicine, Pharmacy and Health Ethics Committee (see Appendix 3). This was granted in August 2014, following their suggested amendments. Ethics committees are essential in any piece of research as they help to protect the rights of the participants, ensure integrity of the research, and minimise any potential harm. The focus of the ethical review was largely around participant confidentiality, anonymity, data security, and potential risks to either the researcher or the participant.

Ethical considerations were important throughout the project, not just at the initial stage for approval by Durham Ethics committee. As the research evolved, ethical considerations became more evident. The realist approach to data collection also meant that sources were sought that had not been planned initially, particularly the expert group evident towards the end of the project. The content of interview guides were developed throughout to reflect the emerging themes. Obstacles were also met on a few occasions, in which small changes were made to data collection. Therefore, each step of the research was considered in terms of the ethical implications and, where necessary, amendments were reviewed and approved by Durham University (see Appendix 4).

5.4.1 Ethical considerations

The main ethical considerations that arose were due to the small sample sizes within each group of participants, thus reducing anonymity. This was largely due to the small number of OMGs attending the intervention at AH. The small sample size was heightened by the fact that OMGs were a distinct minority of doctors in some Trusts. This required careful consideration to protect their anonymity and confidentiality. It was decided that full demographic data would not be collected. Identifiable information discussed in interviews was also omitted.

OMGs were further asked to provide an ID code that was anonymous, unique and memorable (e.g. the last 4 digits of their phone number) on all questionnaires to ensure anonymity as much as possible. Participants were asked to provide this code on an additional slip, along with their name, that was given to an educational administrator to create a key coding system. This enabled performance data and clinical feedback of individuals to be anonymised (discussed in later sections).

Feedback on OMG transition was also sought from their supervisors and peers, in which consent was gained from the OMG prior to their recruitment. The same type of personal and

sensitive information was likely to be disclosed, and again, the same anonymity was assured. No demographic information was reported about supervisors or 'buddies'. Any identifiable information given about the OMG being discussed was removed from quotes.

Cover letters, information sheets, verbal introduction to the research, and consent forms were given to all individuals that participated in the research (see Appendix 5 for examples). Due to the longitudinal nature of the study, verbal information was reiterated before other data collection took place throughout the year. It was critical that OMGs understood that all information would be anonymised, particularly where discussions were around their performance or relationships with colleagues. Participants were also assured that the main purpose of the information being collected was to feed into a PhD, rather than being collected by the organisation that they worked. This was not only to reduce their anxiety, but also to encourage them to be open and honest in their responses.

5.5 Settings (including recruitment of comparison Trust sites)

The majority of the data collected was from AH as the focal intervention was POD.

The process of recruiting other Trusts from the North East to take part in the research took time. Thankfully due to engagement with the regional interventions (case studies presented in Chapter 4), key contacts were made within Health Education England North East (HEENE) who were keen for certain Trusts to participate. HEENE enthusiasm and engagement proved to be a great asset to the research process. The sites that took part in the research were Blossomvale Hospital (BH) and Clearwater Hospital (CH) (described in Chapter 6). As stated earlier, pseudonyms are used to ensure anonymity of individual sites as much as possible.

5.5.1 Gaining access to research sites: R&D

To access AH staff to conduct the evaluation, their Trust Research and Development (R&D) committee needed to approve the research. Following ethical approval from Durham University, an application was submitted to R&D. Approval was granted at the end of August 2014.

A research passport was obtained so that access to other Trusts could be approved if needed. This was quite a lengthy process but given the iterative and unpredictable nature of a realist evaluation, it was important to get quick access to other sites later, if required. Where amendments were approved by Durham University, these were sent to the R&D committee.

R&D approval was gained from BH (November 2014) and CH (November 2015). Approval was given to access another NHS Foundation Trust (December 2014), however this site was not included due to a low intake of OMGs. University ethics was deemed enough to conduct interviews with OMGs that attended regional interventions (discussed in Chapter 6).

Throughout the project, the research was reviewed a total of 12 times (including Durham University ethics committee and each R&D departments) This therefore illustrates a robust consideration of ethical and R&D issues.

5.6 Sampling and recruitment of participants

Sampling is the important process of selecting units (e.g., people, organisations, time periods) from a population of interest. The aim of all sampling approaches is to draw a representative sample from the population, so that enough information can be drawn from the data to be generalised back to the population[262].

Pawson and Tilley[5] recommended respondent selection to be based on their 'CMO investigation potential'. Each component of a middle-range theory; context, mechanism or outcome, triggers the need for a different kind of respondent (illustrated when presenting each sample below). This was taken into consideration throughout. A broad range of practitioners and stakeholders had already illustrated specific ideas on how they believed POD (and similar interventions) to work. The synthesis provided this quality information regarding the underlying programme theory, largely from the perspective of theorists and practitioners who knew about such interventions[263]. Different points of views were therefore targeted to ensure consensus[258].

Use of source triangulation, following the principles of the realist approach and assumption of an objective reality[264], allowed an in-depth understanding of POD from multiple perspectives. Multiple measures are important as they often cancel out the effects of errors arising from individual measurements. It was felt that the chosen samples would be able to illustrate, from a triangulation of their perspectives, if POD was successful in supporting transition. These individuals were the experts that could shed light on how and why the intervention did or didn't work (identifying intended as well as unintended outcomes). These different sources also added specific contributions to the programme theory. All participants were asked to validate the three aspects of the programme theory.

5.6.1 Purposive sampling

Apart from the POD (intervention) group, which included the entire population, 'purposive sampling' was used throughout the research. Informants that had a diverse range of views and experiences of POD, and interventions alike, were selected. It was also ensured that the chosen samples could be used to test the relevant aspects of the programme theory, and explore implementation barriers and facilitators.

Due to the small number of OMGs in each Trust, and nature of the realist approach, it was important to remember that findings were context specific. However, the small sample sizes for each group were appropriate for the complex and detailed design of the research[262]. This was supported by the fact that data saturation was reached; no more themes or theories emerging from the data.

5.6.1.1 Recruitment: OMGs POD intervention

All OMGs that took part in POD were invited to take part in this research. OMGs were recruited on the first day of the induction training. All attendees from this day completed pre- and post- intervention questionnaires (see section 5.7.1.3). Other OMGs, that did not attend all modules of the induction training, were only recruited for interviews. All OMGs that attended POD were successfully recruited to take part in interviews. Only one individual from POD2 did not take part because they left the Trust (see Table 4 and 5). Two OMGs were uncontactable at 12 months during POD1.

This was an essential group to interview, as they could provide insight into their overall transition to the UK. They were also able to provide rich data about mechanisms, often the hardest concept to gather evidence about.

Table 4. Cohort 1 interview participants

Cohort 1 (POD1)	OMG intervention	Supervisors	'Buddies'	OMG comparator
Number of participants recruited to take part 3 month post POD	**13/13**	**16/18**	**4/4**	HEENE (WTUKP) – 12/18 HEENE (communication) – 5/7 AH – 4/5 BH – 3/4 Total - 27
Number of participants that took part 3 month post POD	**13**	**13**	**4**	HEENE (WTUKP) – 3 HEENE (communication) - 3 AH – 4 BH – 2 Total - **12**
Number of participants invited again to take part 12 month post POD	**13**	**15** *(majority same as invited at 3 month)*	N/A	**12**
Number of participants that took part 12 month post POD	**11**	**13**	N/A	**10**

Table 5. Cohort 2 interview participants

Cohort 2 (POD2)	OMG intervention	Supervisors	'Buddies'	OMG comparator
Number of participants recruited to take part 3 month post POD	**8/8**	**12/14**	**2/2**	CH – 5/6 AH – 4/6 Total - 9
Number of participants that took part 3 month post POD	**7**	**7**	**2**	CH - 3 AH - 3 Total - **6**
Number of participants invited to take part 12 month post POD	**7**	***13*** *(majority same as invited at 3 month)*	N/A	**6**
Number of participants that took part 12 month post POD	**7**	**8**	N/A	**4**

5.6.1.2 Recruitment: Supervisors from AH

All clinical and educational supervisors of those who took part in the intervention were approached for recruitment at one of their monthly supervision meetings. Names and contact information of both clinical and educational supervisors were also provided by the educational department for each OMG. Of those invited (n=32), 28 supervisors were recruited. Eight of these supervisors failed to take part (see Tables 4 & 5). However, since both clinical and educational supervisors were contacted, data was successful collected about each OMG.

The main purpose of these interviews was to explore the middle-range theories from the supervisor point of view. Outcomes of OMG performance following POD was also sought (see section 5.7.4.3). Supervisor perspectives were particularly helpful as they could offer both opinions and experiences of OMG transition. The role of the supervisor was also explored. Supervisors were also asked about OMGs who did not attend POD.

5.6.1.3 Recruitment: Buddies from AH

Buddies of OMGs were recruited at the initial buddying session. Those who could not attend were sent an invite through the educational department. All of those recruited took part (n=6) (see Tables 4 & 5).

Buddies were recruited to explore in more detail how the buddying aspect of the intervention worked and their interactions with the OMGs. It was felt that they could offer an insight from the perspective of a colleague as to how the OMGs were adjusting to the workplace and explore the proposed middle-range theories from this perspective. The role of the buddy was also explored.

5.6.1.4 Recruitment: Comparison sample from AH

The comparison sample of new OMGs at AH who did not attend POD were identified by supervisors and the educational department. Of those invited (n=11) eight were recruited. One OMG failed to take part during cohort 2 (see Tables 4 & 5).

They were chosen to provide insight from the perspective of OMGs who had not attended POD and to provide an alternative experience of transition. The purpose was also to explore the other contextual factors proposed in the programme theory, particularly at the organisational level. It was of interest to see the difference between the two groups' experiences, within the same context of AH.

5.6.1.5 Recruitment: Comparison sample from HEENE interventions

OMGs who attended the regional interventions were recruited when observing them as case studies (presented in Chapter 4). Interventions included the HEENE induction and HEENE communication training (discussed in Chapter 6). Numbers depended on how many OMGs attended the intervention (n=25). Of those recruited on the day (n=17), 11 failed to continue to take part (see Tables 4 & 5). The reason for this was largely due to staff retention issues and will be discussed in the findings.

It was of interest to explore their experiences and different transitional outcomes following the different interventions.

5.6.1.6 Recruitment: Comparison sample from other North East Trusts

The comparison samples from other Trusts in the North East were recruited through engagement with the educational directors of those Trusts wanting to develop a similar intervention to POD within their own Trust. Educational departments were asked to identify all new OMGs within their Trust so that an invitation could be sent to them about the research. These numbers depended on the number of OMGs starting work within each Trust (10 OMGs were invited to take part). Of those recruited (n=8), three failed to respond (see Tables 4 & 5). They were selected to provide insight on OMG transition without any intervention. Interviews explored the contextual factors outside of the intervention that were deemed important for successful transition. It was also important to explore other contexts where they wished to implement interventions, but were unsuccessful in doing so, or faced difficulties in aiding transition. It was felt this would complement the project and help to illustrate the contextual facilitators and barriers of intervention success.

5.6.1.7 Recruitment: Expert sample

The expert sample included intervention implementers and policy makers from a number of organisations (see Table 6). They were chosen to provide rich data about the functioning of POD (and interventions alike), what is likely to lead to success, and to refine and validate the applicability of the final programme theory. All of those invited took part in the interviews (n=6).

Table 6. Cohort 2 interview participants (experts)

Experts	Intervention lead - GMC	Clinical Director of Education - Cumbria	Intervention lead - Oxford	Intervention lead - Manchester	Education lead - Royal College of Psychiatrists	Education lead - Health Education England North East
Recruited	1	1	1	1	1	1
Took part	1	1	1	1	1	1

5.7 Research methods

Qualitative methods were the primary focus of this evaluation. Qualitative approaches are often favoured in the realist approach as they maximise the information gathered. The instruments used are more flexible and the iterative approach to analysis and further data collection ensure all aspects of the programme theory are explored, developed and tested (CMOc)[265]. Qualitative data collection was particularly important in investigating mechanisms, enabling an understanding of the reasoning of stakeholders (those impacting upon the success of the intervention, with a particular focus on OMGs).

Maxwell[266] states that re-testing findings against additional/alternative data should be an inherent part of the research practice. Therefore, exploration of comparative data and exploration of POD over two years was important. It was also anticipated that the intervention would change following the development of theory. In-depth exploration was needed to understand the success of this, whilst also testing the theories at a different point in time.

Quantitative data was collected to explore performance (e.g. number of incidents) and transitional outcomes (e.g. cultural adjustment). Initial outcomes following the training elements of the intervention were also assessed, largely as increased knowledge and understanding was the primary objective of the training sessions. This data also enabled understanding about context and OMG reasoning and attitudes. Patterns of context, mechanisms or outcomes that arose from questionnaires (see next section) were also explored during the interviews. As the theory was refined, questions were revised to ensure

all aspects of the programme theory were tested and explanations of the mechanisms fully explored[263].

5.7.1 Questionnaires

Given that the training aspects of the overall intervention were implemented early in transition, these questionnaires could only explore initial perceptions of learning, attitudes and overall transition (i.e. perceived cultural adjustment). Interviews (section 5.7.3) and additional outcome data (5.7.4) were used to further explore these and later transitional issues.

It was initially intended that questionnaires would focus on perceived outcomes of training, however as the theory developed, the questionnaires were able to provide data on both context and mechanisms e.g. self-efficacy. For many OMGs, self-efficacy could be considered an outcome, but in terms of the proposed programme theory, it was a mechanism.

As the intervention developed, the questionnaires also had to reflect this (for example, the simulation questionnaire was removed for the second cohort as simulation was no longer included). The core questions remained the same.

5.7.1.1 Pilot of questionnaires

All questionnaires were piloted prior to their implementation. Questionnaire data was collected during two pilots of the intervention (May 2014 and July 2014; n=16). The majority of amendments were made following the pilot in May 2014. An anxiety scale was removed as the sample size was too small and anxiety could not be assessed adequately through the use of questionnaires; cause and effect could not easily be established without a detailed assessment. It was decided that anxiety could be better explored through interviews. The initial expectations and needs analysis sections were also amended following this pilot.

Likert scales were amended for some sections (those developed for the purpose of this research, not published questionnaires) so that scoring was clearer for OMGs and so that results could be averaged at the analysis stage; enabling a better illustration of mean scores as they became more standardised between different sections (all of the scale data was normally distributed so therefore it was justifiable to treat it as interval)[267]. The scale of the questionnaire used during simulation training also needed to be made clearer to ensure correct scoring. Following participant feedback, refinement was made to ensure understanding of questions e.g. the definition of 'bureaucracy' was added.

The piloting was particularly important as some sections of the questionnaire had been specifically developed for use with POD. As the OMG literature had focused mainly on quantifiable outcomes of specific skills, no published questionnaire was readily available for adaption. The majority of the developed questionnaire consisted of open-text boxes, yes/no answers and tick boxes (see Appendix 6). Care was taken to ensure questions were appropriate and fit for purpose. A small self-efficacy scale was also developed to reflect the aims of the intervention. The development of this was guided by the work of Bandura[129]. Reliability was assessed in SPSS using Cronbach's Alpha. The score was $\alpha = 0.9$, which highlighted internal consistency between the questions.

5.7.1.2 Data collection

The questionnaires contained measures that were relevant to the training and had previously been used within OMG research. The questionnaires did not measure knowledge alone, but looked at attitudes and cultural adjustment of the trainees. It was expected, as evident in the programme theory, that these factors would ultimately impact upon performance and overall transition. The included questionnaires are listed below.

All questionnaires contained a cover sheet and information sheet. Consent from OMGs to participate in all aspects of the evaluation i.e. questionnaire, interview, permission for performance data to be retrieved etc., was sought during this first contact.

5.7.1.2.1 Procedure

Participants were asked to complete pre- and post- intervention questionnaires (see Appendix 6). These were distributed during the first and last session of POD. This enabled the comparison of self-reported attitudes; particularly concerning areas such as knowledge, communication, and culture, prior to and after the training element of the intervention. Simulation-specific feedback and information on self-performance /peer performance was also gathered (only cohort 1 took part in simulation training).

5.7.1.2.2 Pre-intervention questionnaires

1) Expectations and needs analysis

Based on findings from the realist synthesis, this section of the questionnaire was developed to find out what OMGs expected to gain from the training and what aspects of their transition they felt needed addressing. It assessed whether they felt they needed to participate in such training, the level of support they felt they were receiving, their current attitude towards

professional development, and motivation to improve practice. Confidence (self-efficacy) in current abilities and knowledge about the NHS were also explored across 9-items, participants having to respond using a scale from 'strongly agree' to 'strongly disagree'. Particular focus was on areas that were targeted through the training (largely based on GMC best practice).

2) Revised Sociocultural Adaptation Scale[268]

This 21-item questionnaire was chosen as it contained subscales that were highly relevant to the cultural issues found to impact upon transition. It was important to look at both work and non-related work issues as the realist synthesis failed to provide evidence on more general adjustment originally thought to be associated with OMG transition. The subscales were interpersonal communication, academic/work performance, personal interests & community involvement, ecological adaptation and language proficiency. Participants were asked to rate their competence on each the behaviours using a scale from 'not at all competent' to 'extremely competent'. Example questions included asking participants to rate how competent they feel they are at 'working effectively with other students/work colleagues', 'interpreting and responding to other people's emotions' and 'attending or participating in community activities'.

3) Communication Self-Efficacy[159, 269]

This 9-item questionnaire was originally developed to measure self-efficacy in health professionals dealing with cancer patients; looking at the role that self-efficacy plays in abilities to assess patient concerns. However, it had been used with physicians who had participated in communication skills courses. Self-efficacy was measured using pre/post course to indicate improvements. Individuals were asked 'How certain are you that you can successfully perform the following tasks?'. Responses ranged from 1 (very uncertain) to 10 (very certain). The self-efficacy score was the sum of responses across tasks. An example question is how they 'communicate bad news to a patient'. This questionnaire was chosen as it assessed both learning and self-efficacy.

4) Patient-Practitioner Orientation Scale (PPOS)[270]

The PPOS was an 18-item questionnaire that differentiated between patient-centred versus doctor-centred orientation, measuring attitudes along two dimensions: sharing and caring. Participants were asked to indicate on a Likert scale, ranging from 'strongly agree' to 'strongly disagree', the extent to which they agreed with the statements. The 'sharing'

subscale consisted of 9 items, which reflected the extent to which the participant believed that the patient should receive information and be involved in the decision-making process. The other nine items, the 'caring' subscale, assessed whether the patients' expectations, lifestyle and feelings were taken into consideration during a consultation. Higher scores indicated a more patient-centred orientation. The purpose of including this questionnaire was to explore whether the training impacted upon participants' attitudes and understanding towards UK practice.

5.7.1.2.3 Post-intervention questionnaires

1) Expectations and needs analysis (including evaluation of training)

Based on the findings from the realist synthesis, this sought to find out whether the needs and expectations that were expressed at the start of the training were met. Confidence in skills and knowledge was also assessed again to see if there was an increase after training. Information concerning content and implementation of the training were also gathered. It also explored other areas of the programme theory such as need for ongoing support, relationships, motivation to develop further, future expectations after training, feelings of preparedness and what may have hindered successful outcomes of the intervention.

The following questionnaires were the same as those given pre-intervention:

2) Revised Sociocultural Adaptation Scale[268] (as in section 5.7.1.2.2)

3) Communication Self-Efficacy[159, 269] (as in section 5.7.1.2.2)

4) Patient-Practitioner Orientation Scale (PPOS)[270] (as in section 5.7.1.2.2)

5.7.1.2.4 Simulation training questionnaires

1) George's Patient Safety in Simulation tool (GPSS)[271]

This tool was selected as it was a current tool that had been developed and piloted to test improvements in postgraduate medical trainees. The GPSS tool could be used effectively in a simulation based learning environment, had good inter-rater reliability and was likely to mirror a real-life situation around patient safety. It measured four domains that POD was hoping to improve on; clinical judgement, prevention of medication errors, communication and effective teamwork. Respondents were asked to mark performance according to the most appropriate statement. Six behaviours within each of the four domains were being

assessed. For each of the behaviours, there were three possible statement options; resulting in an overall mark of either 'satisfactory', 'borderline' or 'unsatisfactory'.

Simulation sessions involved two participants taking part in the simulation and two observing from another room. The observers were asked to complete the tool for one peer and provide feedback in the debrief. A modified version of the tool, asking participants to rate their own performance, was also given to participants at the end of their session, so that a self-report measure could be obtained. The group were given information about how to use the tool and an opportunity to highlight any issues. Both participant and observer feedback on performance was collected to explore and highlight issues around insight, to promote group discussion and reflection in the debrief, and to aid transformative and observational learning. The decision to include this tool was very much influenced by the programme theory.

2) Adapted PNCI® Simulation Effectiveness Tool[272]

The Simulation Effectiveness Tool was a relatively new instrument that showed much promise and value in assessing effectiveness of simulation. The scale had the capacity to measure many aspects of the simulation training. The underlying themes of learning and confidence were highly relevant to the learning outcomes of the simulation training with OMGs and therefore questions were slightly adapted to fit the scenarios.

The simulation tools were removed from data collection with cohort 2. Objective Structured Clinical Exams (OSCE) took the place of simulation (following the findings presented in Chapter 7). Performance was assessed by educators who had their own assessment documents. These were shared with participants during a debrief session.

5.7.1.3 Sample size of questionnaire participants

A total of 16 participants completed the pre- and post- questionnaires (cohort 1 – n=7; cohort 2 – n=9). All OMGs that took part in the simulation sessions used the simulation tools (n=8).

5.7.1.4 Limitations of questionnaires

The sample size of OMGs attending POD was small, therefore findings from the questionnaires were limited. Questionnaires were further limited due to the self-reported outcomes. However, perceptions were sought and triangulation of data sought to overcome issues with reporting bias.

The data collected was also unable to provide rich detail needed for theoretical exploration. Open-text boxes were included, however answers could be ambiguous and space was

limited. Questionnaire design is ultimately inflexible and does not allow an iterative approach to date collection[121]. However, because mixed methods were used, and their intended use for the evaluation was to explore specific aspects of the programme theory, this was not a major concern.

5.7.2 Researcher observations of POD

The 'real time' nature of the evaluation meant that researcher observations took place throughout, adding a further source of triangulation[273, 274]. Observations provided a good opportunity to feed valuable data into the development of both the intervention and the programme theory. It also helped to understand more about how it worked. Factors that could shed light on mechanisms were particularly sought. Informal discussions with OMGs, group discussions, and observation of their reactions (which would not have been recorded in the questionnaire), proved particularly valuable.

5.7.2.1 Procedure

A relatively unstructured approach was taken; discussions often arising as a result of participant experiences within the intervention. The identified middle-range theories from Chapter 4 helped the observational process. All aspects of the intervention were observed, including the implementation of support interventions. Observations were recorded through field notes. Care was taken to look for disconfirming evidence.

5.7.3 Interviews

In evaluation research, particularly in formative, process and development approaches, interviews are frequently the main and only tool used to generate data about intervention effectiveness[263]. Interviews are also the most widely used method of data collection in social sciences. Interviews were necessary in this research to build knowledge and ensure a full exploration of the programme theory took place, including unexpected processes.

The interviews sought to understand the views of those who experienced, or were involved in the intervention, compared with the original theories about how POD was working[263]. Interviews were centred on OMG transition, and staff views and experiences, of being involved with interventions to support OMG transition. In depth, semi-structured interviews were deemed the most appropriate method when interviewing participants as they provided rich and detailed data, and ensured questioning was not too rigid, allowing for further exploration[275]. Interviews began with more broad questions, such as describing initial difficulties OMGs face in their transition to the NHS. The interviews then explored specific

elements of the programme theory, depending on what aspects of the theory were being sought from that particular individual. Open-ended questions were used throughout to allow for probing to gain a deeper understanding. Interviewees were aware that other groups were being interviewed, that perhaps would have different views. This is thought to influence participants in offering more detailed explanations[276]. Knowing that the researcher was interviewing others who may have different perspectives was hoped to encourage participants to think about OMG transition and the intervention in general, rather than the specifics of their own experience.

The subject matter of all of the interviews in this project was the programme theory, the purpose being for interviewees to confirm, falsify and refine the theory[263]. A teacher–learner cycle was integral to the realist evaluation[263]. It involved the researcher being fairly open about how they expected interventions to support OMG transition and the participant then 'teaching' the researcher about what they perceived to explain the successes (or failures) of OMG interventions.

5.7.3.1 Data collection of interviews

Topic guides were used to ensure that relevant aspects of theory were explored and each group of participants were asked the same questions. Similar interview protocols were used for all groups[264]. However, when interviewing different samples of participants, different aspects of the programme theory were focused on. Interviews were therefore designed around their awareness and experiences of the interventions for OMGs, including their reasoning about specific propositions[4, 263]. Participants still very much steered the direction of the interviews. These guides were developed using the programme theory developed from the realist synthesis. These were checked and refined by both PhD supervisors and those on the POD planning team. Initial interview questions were piloted on an overseas doctor studying at Durham University.

A specific topic guide was created for each group of participants. However, as new aspects of theory emerged, questions were revised and new areas explored further in the interviews. New elements were often added to the topic guides. Cohort 1 interview guides were also developed following analysis of the first set of interviews. The topic guides used with the second cohort also reflected development of theory, as well as the developed intervention (e.g. simulation taken out, OSCE-style stations added). Not all aspects of the initial programme theory would have had the same value in the transition process, therefore it was important to explore where more emphasis should be.

Confirmation bias is a challenge in realist methods, but Pawson[122] stated that you should look to disprove your theory in interviews. Therefore, the framing of the questions posed was crucial. There was a conscious effort throughout to ask neutral questions and not merely seek for participants to agree. It was therefore important to obtain rich accounts and examples from participants to illustrate their response. Realist hypotheses are not confirmed or abandoned through saturation obtained following qualitative interviews, but through relevance and rigour[122].

All participants were given a cover letter and information sheet, and gave informed consent prior to the interview taking place (see also section 4.4.1 and 5.7.1.2). As most participants took part in a follow up interview, verbal consent was obtained again prior to it taking place.

5.7.3.2 Procedure

Two interviews took place with each OMG and their supervisors over a one-year period. Each interview lasted around 20-40 minutes each. The first interview took place three months after POD. The interview was conducted at this specific time as OMGs were likely to be in the early stages of their transition and were able to share early experiences, but also were likely to need to adjust further. The questionnaires presented in section 5.7.1 enabled initial impact of the intervention to be explored, however interviews intended to assess their transition after having the time to adjust. The second interview at one-year post-POD focused on later experiences and long term impact. Looking at differences in responses from intervention and non-intervention groups was important here. A follow up interview was also useful in terms of refining the programme theory, questions reflecting the researchers increased knowledge that resulted from the initial data collection. This use of time triangulation helped to understand experiences at a deeper level, rather than merely presenting a 'snapshot'. Only one interview was conducted with buddies (three-month post-POD) as the focus was on the intervention, and barriers to initial implementation and engagement. Long term impact of buddying and engagement was discussed with OMGs.

Face to face interviews were the preferred modality, some OMGs specifically stating that they may have difficulty communicating over the telephone. Being face to face was also important in terms of noticing body language and other non-verbal communication, such as facial expressions and hesitations[277]. Telephone interviews took place when face to face was not possible. For those participants from BH, geographical location meant travel was difficult. Documents (e.g. information and consent) were exchanged via email before the telephone interview took place. Although face to face interviews are often preferred over telephone

interviews, there is little evidence suggesting a difference in the quality of data[277]. Participants may in fact feel more relaxed during telephone conversation and therefore more willing to disclose sensitive information[277].

After all other data had been collected, the project moved onto the expert interviews. A realist interview was used with experts[1, 278]. The realist interview involved explaining the programme theory being tested, and then having learned the theory, the experts were able to teach the researcher about the components of the intervention in an informed way. The complexities of OMG transition and interventions were discussed, the teacher-learner role being interchangeable throughout[263]. This method was not fully utilised with OMGs because in some cultures it is considered rude or inappropriate to disagree with an 'expert'[279]. Therefore, the co-created dialogue, which was recommended by Pawson & Tilley, was only used with experts at the end of the project. The purpose of these final interviews was to essentially approve or disprove the final theory[5]. This was crucial for validating the researcher's interpretation of what was or was not working, to enable refinement of the programme theory.

All interviews were audio recorded with the participants' permission and transcribed verbatim. Notes were also taken during the interviews.

5.7.3.3 Sample size of interview participants

A total of 123 interviews were conducted across two years (see Tables 4 and 5 in section 5.6.1.1). The two cohorts were referred to as POD1 and POD2 (or NON1 and NON2 when referring to comparative groups).

Thirty-eight interviews were conducted with OMGs who engaged with the intervention. These took place three months after POD was implemented (POD1 – n= 13, POD2 – n= 7) and one year following implementation (POD1 – n= 11, POD2 – n= 7).

Forty-one interviews were conducted with supervisors (both clinical and educational) of OMGs who engaged with POD. These took place three months after POD was implemented (POD1 – n= 13, POD2 – n= 7) and one year following implementation (POD1 – n= 13, POD2 – n= 8).

Six interviews with 'buddies' of OMGs who engaged with POD were conducted (POD1 - n= 4, POD2 - n= 2). These took place 3 months after POD had been implemented.

A total of 32 interviews took place with OMGs who were classed as the non-intervention (comparator) group. These took place at the same time as interviews with the intervention group; at 3 months (NON1 – n= 12, NON2 – n= 6), and after one year (NON1 – n= 10, NON2 – n= 4).

A total of six interviews with 'experts' took plac e at the end of the project, between July and August 2016 (see Table 6).

5.7.3.4 Limitations of interviews

Although there was an adequate total number of interviews, some groups of participants had a small sample size. This was due to the small number of OMGs that attended POD. Two years of data collection helped to overcome this issue.

Interview data can be criticised for researcher bias and social desirability of the participant. However, given the clear framework used to guide data collection and analysis, it was hoped that this would not be an issue.

Participants may have also failed to give accurate accounts, particularly in terms of poor performance (either about themselves or others), as they may have feared the consequences of disclosing such information (particularly OMGs). Recall bias may have led to further error in retrieval of their recollections about past events or experiences. Additionally, responses may have been dependent on how the participants felt at the time of the interview. Given some of the cultural differences, questions may have also been misunderstood. The triangulation of sources helped to overcome such issues.

5.7.4 Additional outcome data to explore OMG transition

Findings from Chapter 4 suggested that successful intervention outcomes include work adjustment, interaction adjustment and cultural adjustment. Identifying these patterns of outcomes was important so that the mechanisms generating those outcomes could be analysed (and then linked to contexts in which particular mechanisms did or did not 'fire').

Whilst the questionnaires presented in section 5.7.1 were useful, these complex transitional outcomes were not explored (only addressing initial perceptions of adjustment and learning from the POD training). Given that the intervention was made up of a number of components over an extended period of time, long term transitional outcomes were also sought.

Although interviews were useful in exploring longer term adjustment, a more quantitative and rigorous exploration of adjustment outcomes was needed. Assessing the overall quality

of the transition process (transition as an ongoing process being highlighted in the initial realist synthesis) would be beneficial for both OMGs and the NHS.

The outcomes extracted from the realist synthesis largely focused on workplace adjustment; more specifically post-intervention performance and specific skills. Therefore, it was important to explore the other areas of work adjustment that had not been explored fully. Cultural and interaction adjustment are very much related to overall work adjustment. Although these areas were explored when performance data was collected (section 5.7.4.1), interviews were the most appropriate method to explore them in more detail.

The different types of outcome data collected included Educational Governance data, retention and career progression data, and supervisor feedback.

5.7.4.1 Educational Governance data

Educational Governance (EG) is the systems and standards within the UK through which organisations control their educational activities and demonstrate accountability for and the continuous improvement of the quality of education (GMC). The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training. The systems enable organisations to monitor performance of their doctors against the standards of others, responding when standards are not being met. Incidents that should be recorded on these systems include Serious Untoward Incidents (SUIs) and complaints.

Chapter 1 highlighted that OMGs are more likely to be involved in performance related incidents than UK graduates. According to the programme theory, it was anticipated that OMGs would be involved in fewer incidents following POD than if they did not attend POD. It was therefore decided that EG data would be collected at AH across the two-year evaluation. It was of interest to explore performance data of those that took part in POD, OMGs that did not have any exposure to POD, and UK graduates.

Had data been available, it would have been beneficial to look at EG data from previous years and compare to the years where interventions had been implemented, particularly as the culture and awareness of the hospital were likely to change. However, data was only available from March 2014 onwards. EG data was therefore retrieved from August 2014 to July 2015 and from August 2015 to July 2016. It is also important to note that sample size for those that attended POD was small and therefore limited analysis of the EG data.

5.7.4.1.1 Procedure

The quality officer within the education department at AH gathered the performance data from the database for the time periods requested. GMC numbers were then used to identify those who graduated in the UK and those who graduated overseas. Those who attended POD were also highlighted. Data included the date of incident, the theme of the incident, how it was resolved and any additional information.

Only junior doctors, not consultants, were included. Complaints about more senior doctors were not included on the education system. Therefore, at the analysis stage, any data analysed excluded these senior levels. Also, only those in Trust grade or in training posts attended POD, so it was important to collect EG data for everyone at the same level.

It was not possible to explore whether the intervention had a direct impact on this data. Due to the design of the project, outcome data from the other Trusts involved in the research could not be explored. Contextual factors were also likely to impact on the data collected in these systems, for example, the different Trusts illustrated different levels of reporting and the way they implemented the EG systems. Some were much more reliable and rigorous than others. Therefore, the focus was on the intervention group and their performance following POD. I felt it was necessary to explore outcome data that could feed into the programme theory, although no clear correlation could be made.

5.7.4.2 Career progression and retention data

The differences in career progression and retention rates between OMGs became apparent during the first cohort of interviews. It was therefore decided that both retention and career progression data would be collected for all OMGs involved in the research. This information was collected through educational departments and interviews. Most OMGs responded to emails even if they had left the hospital that they were working in at the time of the first interview. When only their work email had been provided, contact was not possible. This information helped to further explore the longer term transitional outcomes of the intervention that have been noted previously as needing exploring.

5.7.4.3 Supervisor feedback

Feedback from clinical supervisors at AH who observed performance of OMGs whilst in practice was also used as an outcome measure. This was collected during interviews (section 5.7.3.1). They were specifically asked about performance and progression since the intervention (and before the intervention if appropriate). Where issues with performance

were highlighted, supervisors could shed more light on this. OMG feedback was also sought, but this is perceived performance rather than actual performance. This was a main reason why interviews were conducted with both OMGs and their supervisors. It was also important to gather other information on improved performance as EG data only focused on negative performance issues. It was hoped that supervisor feedback would provide this.

5.7.5 Ongoing discussions with key stakeholders to inform and refine the developed programme theory

As illustrated throughout, various discussions took place with a number of key stakeholders. These took place across the two years. The purpose was to get feedback on both the intervention itself and the middle-range theories that were developing from the analysis. Tracing processes of implementation is an important part of realist evaluations because stakeholders' meanings and reasoning processes about intervention implementation can help identify key contextual differences in the resulting outcome patterns[280]. Discussions took place with those at the participating Trusts; including those involved in developing and implementing interventions, the directors of medical education, postgraduate educators, and programme leads.

Valuable discussions took place at AH, particularly at the POD planning meetings, where the processes of intervention development and refinement were the focus. Attendance at these meetings meant discussions could be facilitated to explore necessary aspects of the programme theory. The group also relayed relevant information concerning practicalities and deliverance of the intervention. Their experience with OMGs within the Trust was also important. The Clinical Director of Education emailed minutes from other meetings, both inside and outside of the Trust, when relevant information was discussed.

It was also interesting to explore POD with those at the comparator Trusts, where they were in the process of developing a similar intervention. All of this information was crucial in refining contextual issues.

Discussions also took place with other Trusts and organisations that were not formally participating in the evaluation. They had either recently implemented an intervention for OMGs or were planning one. Many of these discussions took place after individuals had approached with interest in the research (such as the Royal College of Physicians). The researcher also contacted other intervention leads throughout the UK (often where names had been given via previous contacts made).

A number of meetings were also attended at HEENE; with the Postgraduate Dean, various educators within HEENE, directors of education and specialty leads, from a number of North East Trusts. Discussions also took place with the GMC after being invited to discuss emerging findings. These provided opportunities for valuable feedback on the emerging programme theory. Conferences also provided another platform for discussion.

Pawson emphasises the importance of theory refinement, or consolidation, through 'digging for nuggets of evidence' in other sources of data (i.e. documents or routinely collected data)[278]. Published data from the GMC was explored. Policy documents about other interventions were sought where available and minutes of meetings sent to me.

5.8 Analytic approach

The analytic approach used at the evaluation phase of this research was not a defined, separate stage of the process, but was an ongoing iterative method of placing 'nuggets' of data within a wider explanation[278]. The analysis of realist datasets is constructed and timed differently to most typical evaluations[263, 281]. In fact, analysis started long before actual data collection took place. Much guidance was sought from the literature on how to analyse data in realist evaluations[4, 5, 104, 122].

Unlike other intervention evaluations, realist evaluation analyses the data in the form of the CMO configuration patterns that have been discussed throughout[1, 5, 278]. As would be expected, data was analysed using the initial programme theory as a framework (Davidoff). It was important to ensure strings of CMOs (configurations) were extracted, rather than simply listing CMOs. Exploration of direct links were essential.

It was also essential to look for components within the data that didn't fit, as well as those that did. Exploration of the programme theory was the main focus, but there was also an awareness of exploration of the unexpected[263].

5.8.1 Quantitative data analysis

The research methods largely focused on qualitative data collection as it provides interesting and rich examples. However, quantitative data was important to ensure performance outcomes were explored empirically and support findings from the interview data.

5.8.1.1 Questionnaire data

SPSS software was used for the analysis of pre- and post- POD questionnaire data. Descriptive statistics were reported as these illustrated the difference in pre- and post-

questionnaire scores. The dependent t-test was deemed inappropriate for analysis due to the small sample size and non-parametric nature of the data. The Wilcoxon Signed-Rank Test was therefore considered for analysis to compare the two sets of scores. It is the nonparametric test equivalent to the dependent t-test, not assuming normality in the data. The data met the assumptions of the Wilcoxon Signed-Rank test and therefore it was used to compare pre- and post- intervention scores.

Questionnaire data collected from the simulation sessions (cohort 1 only) were also analysed, the focus being on comparison of means. The observer score of performance was compared to a self-rated score of performance. These scores also helped participants in terms of self-awareness and reflection.

5.8.1.2 Performance data

Although merely reporting EG data would help to illustrate the types of incidents that occurred at AH over the course of this project, it would not lead to an understanding about the overall performance of OMGs at AH; particularly what proportion of incidents OMGs represent. In order to calculate this, the total number of doctors working in the hospital had to be known (both UK and non-UK graduates). However, it was difficult to get a staff list for all doctors working at AH as there was no single database to monitor this. During cohort 1, information was unavailable, particularly for those not in training posts (discussed in section 7.3.1.5). However, during cohort 2 (and the development of a new database), data about all postgraduate staff was retrieved. Three staff lists were obtained, which included Foundation doctors, those employed by LET (specialty/core training) and those in non-training posts (Trust Doctors/clinical fellows/clinical attachments etc). GMC numbers were checked to determine place of graduation. Consultant and specialist doctors were not monitored by the Education Department.

It was acknowledged that these lists were not entirely accurate due to doctors starting and leaving on a regular basis. Therefore, monthly starters and leavers forms from across the year were used to alter information accordingly. However, it still proved difficult to get an accurate number of doctors that worked at AH because the lists were not updated on a regular basis, as evidenced by the fact that some of the OMGs involved in this project were unknown to the Education Department and did not appear on any list. The numbers retrieved were therefore estimations, rather than definitive numbers.

Chi-square tests, using SPSS, were conducted to analyse the Educational Governance (EG) data. The purpose of this was to see if there was a difference between the variance of performance data for each group (UK graduates and OMGs). The data was checked to ensure the two assumptions of the test were met.

5.8.1.3 Career progression and retention data

Progression and retention data was purely descriptive as numbers were low and the design of the research did not support further analysis of this information. Instead, tables were produced (presented in chapters 7 and 8) to illustrate career progression and retention for the different groups of OMGS that took part in the research.

5.8.2 Qualitative data analysis

To ensure rigour, it was crucial that appropriate techniques were used to analyse the data. Justification and principles of the chosen technique are discussed below.

5.8.2.1 Framework Analysis

Due to the nature of the realist approach, the framework approach was the obvious and most appropriate choice of technique[282]; given that a programme theory had already been developed. Thematic analysis would not have been appropriate as the purpose was to explore the relationships between the contexts, mechanisms and outcomes.

Framework analysis is a flexible, systematic, and rigorous approach that leads to a meaningful interpretation of the data that is relevant to applied needs[283, 284]. It ensures transparency, offers clarity, and ensures an audit trail is provided from the analysis process. It is an excellent tool that helps to manage and map data[284]. The explicit approach very much sits in a thematic methodology. The approach involved several inter-related, but distinct, stages that allowed for theme-based analysis.

Its ontological position adheres closely to subtle realism[285]. This view maintains that the social world exists independently of subjective understanding of the individual, but is only accessible in qualitative research through participant interpretations, which are further interpreted by the researcher[286]. This view very much follows the logic of realist evaluation. Its applied approach is seen as useful for informing both policy and practice, which fits nicely with the applied nature of medical education research. The analysis is shaped by existing ideas and intends to increase understanding; it is less focused on producing new theory[283].

However, both inductive and deductive reasoning are used. This method has been used in other realist evaluations[118, 287].

Framework analysis involves five stages: 1) Familiarisation 2) Identifying a framework 3) Indexing 4) Charting and 5) Mapping and interpretation. The analytic process was not necessarily sequential. Application of these to my analysis are discussed below.

5.8.2.2 Application of the framework approach

All interview transcripts were imported into NVivo 10. Notes from discussions, field notes, policy documents, minutes from meetings, and qualitative elements of the questionnaires were also imported. The five stages of analysis that took place are discussed below.

Familiarisation:

This stage involved gaining an overall view of the data that had been collected. This involved reading the transcripts many times and noting the range, depth and diversity in the data collected. This helped me to notice subtleties and assumptions. Regular discussion about the concepts and themes that emerged from the transcripts took place with supervisors and the POD team. This ensured thematic consistency.

Identifying a framework:

An initial coding frame was developed using the middle-range theories developed in the realist synthesis. The framework was fairly broad and so provided enough guidance to shape data collection and analysis, but was flexible enough to allow theory refinement and the development of new ideas.

This stage of the analysis focused on prior themes - those themes that guided the study aims, emergent issues - those themes that are raised by the participants, and analytic themes - those themes that emerged from patterns and re-occurrences in the data.

The coding frame was adapted and refined to allow new themes as they emerged from the data, for example, alternative mechanisms and explanations were sought where necessary. The analysis focused on refining the explanations as to how the proposed mechanisms unfolded, or did not unfold. The programme theory created a new structure for the data (rather than solely focusing on the original accounts given by participants) that was helpful in developing the CMOcs and ultimately support answering the research questions.

Indexing:

Indexing involved applying the framework to the data. This involved reading the transcripts and marking sections of text which related to components of the programme theory. New components were added where appropriate. This was done using NVivo 10. NVivo proved to be efficient in the process as it ensured all data was stored in one place and multiple codes could be applied to the same piece of data. NVIVO was used to keep an audit trail of developments and allowed refinement of multiple theories. NVivo helped to provide an accurate and transparent picture of the data[288].

Indexing was important in seeing if the data fitted in the framework. Data was coded against the three contextual levels presented in the programme theory and data was coded for each of the proposed CMOc separately. Even though data was stored in NVivo as separate sources (e.g. OMGs, supervisors, buddies), it was analysed by conceptual theme (rather than by source). Each node was linked to a C, M or O. I ensured nodes remained linked as CMOcs– both within and between the three levels. Explicit connections were essential[289], otherwise context of the coded sections would likely have been lost. It was sometimes difficult to illustrate direct links between CMOs in the data, the connections having to be derived logically in the analysis process. At times there were obvious connections in particular statements from participants. Due to the different methods of data collection and difference sources, connections were sometimes hard show. This was particularly true when trying to link the outcome data that was collected separately (all other data was placed into NVIVO). However, it was ensured that the outcome node was always completed, whether it was an observed, anticipated or implied outcome. The second year of data collection also ensured that interviewees were asked to feedback on the specific links between the CMOs being proposed. Expert interviews and ongoing discussions with the POD team and other stakeholders also addressed this.

The coding was essentially just data management and organisation to make the data easier to retrieve. Memos were a key tool throughout the process[290]; enabling reflection on specific CMOcs and discussion of the emerging theory. Reflections on actions became data in their own right. The key ideas (middle-range theories), recorded in memos, were referred to when refining the interview guidelines for the second cohort. All codes highlighted as being key concepts were interrogated more deeply and data was explored to test and refine these theories[282]. All decisions were recorded in memos. Memos were also created to record the debate about the emerging theory and decision making; adding to the audit trail and making all decisions transparent.

A selection of transcripts were discussed at supervision meetings to allow for debate and further exploration of emerging themes. These were also discussed with the POD team at AH.

Charting:

Charting involved collecting all the selected sections under a particular theme and viewing the data as a whole for each theme. Key data was placed in a table to highlight each theme. This process was made much easier using NVivo. Decisions at this stage were based on similarities and differences between the initial programme theory and themes becoming clearer through exploration of the data. A table was produced and discussed with my supervisors. Many of the themes overlapped and at times it was unclear which contextual level the data best fitted. Some new concepts also emerged. The theory was therefore refined to best reflect the data. The second lot of analysis (cohort 2) was focused on ensuring that data fit in only one theme and was less repetitive. It was also important to ensure that the links were fully explored and strong CMOcs were developed. These were then summarised in charts, with a reference linking back to the original source.

Although the data was coded using the CMO concepts, the relationship among them was not always self-evident. It was ensured that each component was explored in terms of its relationship with the other components. Initial findings were discussed in detail with the POD team and other relevant stakeholders (e.g. HEENE, GMC, researchers, and academics). I also presented and discussed early findings at a number of national and international conferences and so received valuable feedback from attendees. This proved to be valuable in terms of critical reflection on the data and findings.

Mapping and interpretation:

The final stage involved bringing the key themes within the data set together and drawing together the findings of the analysis as a whole to address the aims and objectives of the research project. Each data source was analysed separately, but were synthesised towards the latter stages of analysis. The results of the qualitative and quantitative phases were analysed together to develop further context-mechanism-outcome configurations that would explain the transitional process of OMGs as a result of the intervention at AH.

5.8.2.3 Limitations of framework analysis

Framework analysis can be criticised for being a reductionist technique for data analysis[284]. This is particularly the case where a vast amount of data has been collected, and this is then

summarised into overarching concepts. Less attention is often given to context. However, due to the nature of the realist approach, this was always at the forefront of the analysis. Detail was sought throughout.

5.8.3 Developing case specific CMOcs

Detailed narratives were developed to illustrate, and refine, some of the key middle-range theories. The purpose of this was to illustrate the importance of contextual factors beyond the specific intervention. They were also used to look at enabling and disabling factors, leading to both successful and unsuccessful outcomes. They further highlighted the specific activities and efforts that were undertaken to support OMG transition and what impact these had on outcomes. Narratives were used to highlight the interaction between the three contextual levels. Refinement of terminology took place during this stage.

5.8.4 Synthesis

The final stage of analysis was synthesising all of the data – comparing themes and checking against original transcripts, field notes, discussions etc. - to ensure appropriate contexts and to draw out the lessons learnt. By mapping and interpreting all of the analysed data, it allowed for the final refinement of the theory. This stage of framework analysis allowed for the comparison of CMOcs; looking again at the whole data set and checking against original data to ensure appropriate explanations. The charts were reviewed and the developed case studies checked against the programme theory. It was important to ensure all original data sets could be retrieved and were able to illustrate the CMOcs being discussed (transparency), also enhancing rigour. No further changes were made to the CMOcs at this stage. Common themes were established and overlaps were eliminated.

Given the amount of data collected from interviews, it proved difficult to develop concise middle-range theories at the synthesis stage. The presentation of theories to experts helped this process. This last phase of the analysis consisted of determining which CMOcs offered the most robust and plausible explanation of the observed pattern of outcomes. These were then compared with the initial programme theory.

5.8.5 Reflexivity

Research design of any sort has to take into account bias or the potential distortion of research outcomes due to unintended influences from the researcher, as well as research. This is a particularly important issue when collecting and analysing qualitative research[291]. The background of the researcher will influence their approach to research, and more

specifically, their reasoning when formulating and refining programme theories. This was minimised through my interaction with the literature and development of the initial middle-range theories presented in Chapter 4[264].

Reflexivity was an integral part of the realist approach used, particularly as the realist approach involves a great deal of inductive reasoning. It enabled me to thoughtfully consider my relationship with participants and speculate on the ways our interaction may have been influenced by presumptions arising from obvious sources, such as certain demographics (e.g., age, gender, and cultural background). Understanding my role in the interview context helped me to use this knowledge to enhance the transparency, accountability and trustworthiness of my research. Reflective notes were therefore included in all aspects of my data collection and analysis, which became data in their own right[291].

The purpose of this PhD was to evaluate and develop the intervention at AH. However, I also wanted to create a programme theory that could be placed within the wider academic community. This could perhaps have been influenced by my background in psychology, focusing on theoretical perspectives. Many experts commented that it was beneficial to have a viewpoint from a non-medical profession (which I too feel was an advantage at times). I could draw upon theory that others may not perhaps think about. I was not bound to the success of the intervention as it was more important for me to know how and why successful transition was achieved. If the intervention did not work, I wanted to know why.

I also wanted to use my invaluable learning experience during this PhD to add to the realist methodology literature, helping to educate others by illustrating transparency and clear CMOcs in the findings chapters.

My role throughout the research was to offer advice and guidance to AH. My confidence was heightened when I saw that AH was engaging with both the realist approach and findings. I did not envisage such high impact, particularly from other Trusts and at a regional level. There was also much interest from those attending conferences that I was presenting at. This further heightened my confidence in the development of the programme theory.

My communication with the research participants was an explicit part of knowledge production in the evaluation, which is important in qualitative approaches[291]. I managed to successfully build relationships with participants prior to the interviews, particularly OMGs that attended the POD at AH; there being a longer period of interaction. I was also able to build rapport with most 'buddies' and supervisors prior to the interview. As a result, I felt

participants were more open with me about their experiences and did not seem to fear sharing their negative experiences. Most participants were aware that I was external to the Trust, had no authority, and had a non-medical background, and so felt confident in speaking with me.

When I have spoken to other researchers that have worked with OMGs, they highlighted that it can be difficult to recruit this group of doctors. They have likely given up a great deal to get here, so will not want to risk being seen as incompetent or get in trouble by seniors if they say anything negative. Often cultural factors impact on a fear of speaking out. Some OMGs may not be used to giving feedback or being asked about colleagues (particularly seniors). OMGs were also discussing quite sensitive data, particularly when talking about negative experiences and performance. This information is hard to disclose, many stating that they would not talk to their seniors or others in the Trust about it. I was also aware that male participants may have been less willing to disclose information with me (a female). Yet all OMGs that I engaged with wanted to participate in the research and share their experiences of both good and bad practice (so long as it was anonymised). Supervisors also asked for reassurance that interviews were anonymised, as at times, opinions were shared that could cause them to be seen in a negative light (particularly if UK graduates themselves). I reiterated the purpose of the project and so participants felt that their information could potentially lead to future changes in policy and support for OMGs. This was particularly important for OMGs who had faced negative experiences; they very much wanted to help.

I was able to go on a journey with each individual that took part in my project, enabling me to gain an understanding about the transition process. Had I not been involved in every discussion that I was, I would not have been able to immerse myself in the data and be as confident in the final theory development.

5.8.6 Summary of the justification for chosen analytic approach

Qualitative approaches need to have focus if they are to provide meaningful findings. Although the realist approach used in this research began by establishing initial middle-range theories, this did not limit my interpretation of the data. Using a Framework Analysis ensured that analysis was guided by the initial theory and that the process was transparent[292]. Each element of the analysis can be subject to scrutiny, the reflexivity section being essential in illustrating how decisions may have been made.

5.9 Chapter summary

This chapter has described the research methods used and provided a rationale for these choices. It was crucial to illustrate transparency throughout, therefore the techniques and processes discussed were guided by established literature. All aspects of data collection and analysis were fully recorded and reflected upon. The importance of ethical considerations has also been outlined. The research questions and theoretical approach to the research very much determined the use of framework analysis.

The chosen approach allows decision makers to assess whether the POD intervention could be successful in another context, and assists programme planners in adapting the intervention to suit specific contexts.

Chapter 6 Contextualising the case study sites

6.1 Outline

This chapter aims to contextualise the case study sites that were included in the evaluation phase of this project, helping to orientate the reader to the different interventions and settings. As illustrated throughout this PhD, context is crucial in terms of the impact of intended and unintended outcomes. Each of the case study sites presented differ in terms of key facilitators and barriers that impacted upon development and implementation. The description of 'context' in this chapter does not substitute for the 'context' referred to in realist explanation, which refers to the specific aspects of the context that affect how specific mechanisms (do or do not) operate[105].

The chapter begins by presenting the Programme for Overseas Doctors (POD), which was the focus of the evaluation. Although descriptions of the initial intervention (pilots 1, 2 and 3 of POD) have been provided in previous chapters, POD changed quite substantially following recommendations from the realist synthesis in Chapter 4 (POD1 presented in this chapter). Refined versions of POD will be presented at the end of each of the findings chapters (7 and 8); illustrating how the findings have fed into further development of POD. Although the focus of this PhD is not on intervention content and design, it is important to understand how and why the intervention had to change in the hope of improving outcomes.

Key features of the interventions that were attended by Overseas Medical Graduates (OMGs), recruited through Health Education England North East (HEENE) are also presented. Although included in chapter 4 as case studies, these interventions will be explored further in this chapter.

The contexts of the North East Trusts included in the project as comparators will also be presented, perhaps illustrating why implementing such interventions is not a straightforward task.

Potential facilitators and barriers inferred from both policy documents and discussions with key stakeholders prior to the evaluation are briefly discussed for each case study site (explored further in Chapter 7 and 8).

6.2 The Programme for Overseas Doctors at Amity Hospital – Local level implementation

6.2.1 Description of site

Amity Hospital (AH) is located in a deprived area within the North East. The hospital provides emergency and planned medical and surgical care, maternity services and a wide range of diagnostic services and outpatient clinics. The hospital has a high number of OMGs, relative to other hospitals, that are either training or have obtained a post there (discussions with HEENE highlighted this). Over 3 years, 44 OMGs attended POD.

6.2.2 Aims of developing the intervention

When discussing POD with the planning team, it was clear that the purpose of the intervention was to increase the likelihood that OMGs would obtain training posts within the Trust. They felt that increasing initial support would lead to increased performance and retention.

6.2.3 Description of intervention

POD comprised of multiple interventions over the course of one year. Both induction training (see Box 4) and support programmes (buddying scheme and peer support) were implemented following recommendations for ongoing support (presented in Chapter 4). Organisational support was key; the POD planning team helped to develop and implement all elements of POD.

The education department identified potential OMGs to attend the induction. Programme leads were also asked to identify potential candidates (at any level) and ensure that they attend. There was no cost to attend and OMGs could utilise their study leave.

Box 4. Programme for Overseas Doctors implemented in September 2014 (cohort 1)

Programme for Overseas Doctors

Thursday 11th September 2014 – Trust

9.15am	Introduction and Ice-breaker
9.30am	Research
10.15am	Coffee (discussion with former candidate)
10.30am	Personal Development Plan – Snowball
11.30am	Presentation of PDPs
12 noon	SUI / EG teaching
1pm	lunch
2pm	Patient Journey
3pm	Coffee
3.30pm	Hard Days Night
5pm	Close

Friday 12th September 2014 – Trust

12.30pm – 2pm	Lunch & Trust cultural diversity discussion
2pm	Prayers (if applicable)
2pm	Structure of the NHS
3.30pm	Close

Wednesday 17th September 2014 – REACHE

8.30am	Welcome, Introduction to REACHE Course and Icebreaker
9.30am	Summarisation
10.30pm	Break
11.00am	Summarisation
12.30pm	Lunch
1.30pm	History Taking
3.15pm	Break
3.30pm	History Taking
4.30pm	Reflection & Wrap Up

Thursday 18th September 2014 – REACHE

8.30am	Coffee, welcome back and format of the day
9.00am	Group 1 – Simulation – (simulation fellow)
	Group 2 –Angry Patients Teaching and Role Plays
10.30am	Break
10.45am	Group 2 –Breaking Bad News Teaching and Role Plays
12.45pm	Lunch
1.30pm	Group 2 – Simulation – (simulation fellow)
	Group 1 – Angry patients
3.00pm	Break
3.15pm	Group 1 - Breaking Bad News
5.15pm	Finish

Friday 19th September 2014 – REACHE

8.30am	Coffee, welcome back and format of the day
9.00am	SBAR, Handover and Telephone Skills
10.30am	Break
10.45am	SBAR, Handover and Telephone Skills
12.30pm	Lunch
	Trainers/educators to discuss candidates' feedback
1.15pm	Structure of training
1.45 pm	Individual feedback to candidates (appointments for half hour slots)
	Development of individual PDPs and CVs
	Complete job application form (paper copy)
3.15pm	Break
3.40pm	Reflection & Wrap Up
4.10pm	Research
4.30pm	Close

6.2.3.1 Induction training

The induction consisted of 5 days of experiential learning and discussion opportunities that sought to help their transition into working in the NHS (see Figure 17). The intervention addressed communication skills (e.g. use of the Situation, Background, Assessment, Recommendation (SBAR) tool), cultural awareness, good practice (e.g. teamwork), professional and ethical frameworks (e.g. doctor-patient relationship), the structure of the NHS and social integration (colleagues, other staff etc.). All OMGs had the opportunity to practice using simulated scenarios. Expectations and learning needs were established prior to the induction programme beginning. A maximum of 12 participants were recruited for each session to ensure in depth analysis of performance and detailed feedback. Experienced language specialists (REACHE) delivered the communication skills training. REACHE specialise in offering support, guidance and coaching to overseas doctors. The communication sessions covered dealing with angry patients and breaking bad news.

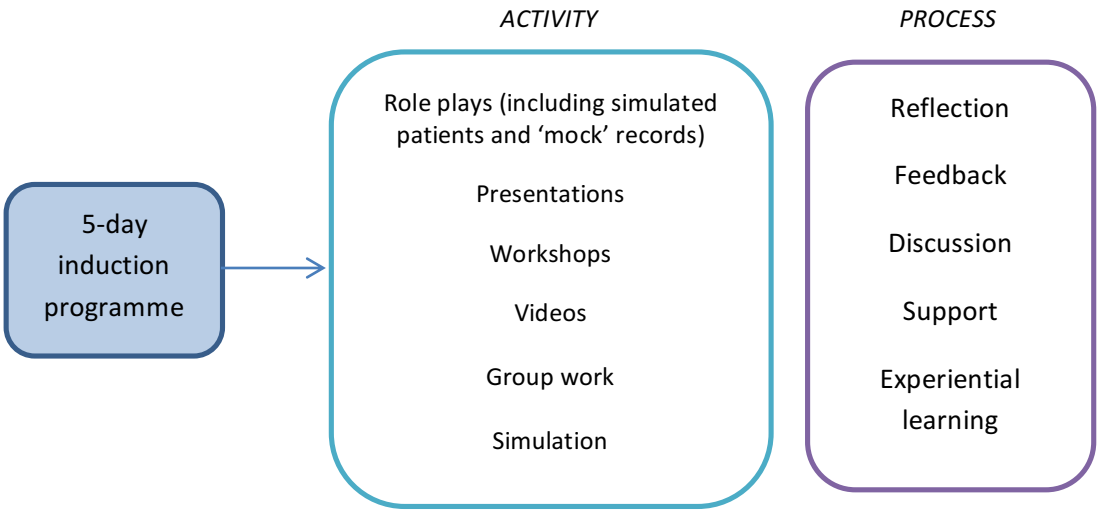


Figure 17. Overview of teaching methods used in the POD induction

Simulation sessions were also included in the induction. The sessions included acute situation scenarios that were based on real situations that occurred within the Trust previously, aiming to develop communication, teamwork, decision making and addressing medical errors. Medical knowledge, whilst discussed, was not the core focus of the session. The scenarios included an acute severe asthma scenario and anaphylaxis scenario in which the disclosure of error was required. Within the simulation, two individuals observed from another room whilst two individuals worked together to see to the patient. A simulated nurse was also present throughout. These sessions ensured experiential learning in a

supervised and supportive environment. Following each simulation session, a debrief was given by the simulation fellow. Peer observation, feedback and reflection took place.

Information containing educational resources and e-learning was also made available to those who attended POD.

6.2.3.2 Support programmes

All OMGs that attended the induction were offered a 'buddy'. This informal support system complemented the initial induction. Buddying aimed to provide a safety net that allowed for questions within a safe environment. It was hoped that both social and professional issues could be addressed. It was felt that support in the initial few weeks of transition was the most crucial, the aim being to avoid early negative experiences. However, engagement with the buddying system was thought to depend on the individual's circumstances (i.e. how long they had been living in the UK, whether they had worked in the NHS before etc.). Both 'buddies' and OMGs were provided with a checklist and guidance on how to develop a successful relationship. This ensured expectations were clear for both parties.

OMGs often felt they were unable to approach those of higher authority as they did not want to be seen as incompetent. It was therefore important that 'buddies' were not seen as a senior, but as a peer. Discussions with OMGs highlighted that both UK and non-UK 'buddies' were welcomed and useful. It largely depended on preferences and individual needs. Both were expected to have their advantages and disadvantages.

Volunteers were recruited by the education department. A 'speed dating' style session took place a few weeks after the induction, allowing for interactions, relationships to be established more organically, and ensuring compatibility both professionally and personally. OMGs were given a 10-minute slot where they could get to know each 'buddy'. Kurre *et al*[293] used a similar approach, which successfully addressed some of the matching issues and barriers associated with buddying schemes. It was expected that once buddying had been effectively put into place, the system would become largely self-sufficient. A dedicated co-ordinator of the scheme was allocated to ensure momentum and this individual was approached by 'buddies' concerning any issues.

A monthly peer support group was also organised by the education department, in which OMGs that attended the previous POD were invited to attend. This extra level of support was sought by OMGs who attended the induction. It was decided that an ongoing peer support

group would be an effective way for OMGs to discuss their individual needs and difficulties, along with successes, within a safe environment.

OMGs wanted the education department to arrange social activities to enhance their social network, however due to limited time and resources this was not possible.

6.2.4 Intended demographics

The intervention was mostly aimed at those new to the NHS, however those who were identified as needing extra support/training were also invited. OMGs were invited regardless of level (see Chapter 7 and 8 for demographics of those who attended). It was proposed that those within their first two years of working in the UK would benefit most from the training and support.

6.2.5 Potential facilitators and barriers

A great deal of investment has been placed into development, implementation and evaluation. The POD planning team were very keen on ensuring that POD was implemented in the best possible way, hence findings from each stage of the research fed into the development of the intervention. Resources did not seem to be an issue for the Trust, despite POD being both resource and labour intensive. Thorough evaluation was also sought, their focus moving from the scientific evidence base to process evaluation and explanation. This support is evident through the funding of this PhD. There were occasions where suggestions faced initial resistance, for example, the need for a buddying scheme. Such issues will be discussed further in the Chapter 7.

The interventions were not mandated, but highly recommended. However, the education department pushed for attendance at POD. Dissemination of findings took place at all opportunities - both within and outside of the Trust, for example, monthly meetings within the Trust and academic conferences.

The location of Amity Hospital (AH) was highlighted as a barrier to transition on a number of occasions. Both OMGs and colleagues noted this. Many OMGs were unaware prior to arrival that the area was deemed as 'deprived'. This was thought to hinder both their practice and quality of life outside of work. Many stated that they would prefer to live in a city, such as Newcastle or Durham. However, many remained working at the hospital due to the high level of support offered to them during their training. Satisfaction surveys in recent years have found it to be one of the top Trusts in the UK in terms of satisfaction of doctors at foundation level. POD is an example of the extended level of support offered by the Trust.

6.3 Supporting Doctors New to UK Practice (Health Education England North East) - Regional level

6.3.1 Description of site

The induction implemented by HEENE took place in the centre of Newcastle so that it was accessible for OMGs throughout the North East.

6.3.2 Responding to GMC recommendations

The intervention was in response to the GMC's recommendation that induction programmes should be implemented for those new to UK practice. HEENE used findings and guidance from the GMC to implement a regional intervention.

The GMCs Welcome to UK Practice event is three hours long. It includes an introduction to the GMC, the healthcare system and multiple ethical scenarios aimed at improving ethical awareness and skills. The components of the interventions were intended to be interactive and 'bring to life' GMC guidance. The concept of induction was tested with key interest groups (e.g. Trusts, deaneries, medical schools) and many pilot events ran across the UK. The GMC focused on designing an accessible intervention that could be adjusted to meet the needs of different doctors. In refining the intervention, they shifted focus to identifying how the greatest impact could be delivered to the largest number of doctors, whilst making the best use of resources. As a result, they developed a suite of products that could be used by individual doctors, with GMC staff or external trainers delivering training. The products developed included an online self-assessment tool, 'Welcome to UK Practice' film, 'Things I wish I'd known when I started in UK practice' film, filmed ethical scenarios, and a communication session.

6.3.3 Aims of developing the intervention

The GMC[41] intended to implement induction programmes that would improve awareness and understanding of good medical practice among doctors who were new to practice in the UK and help them practice safely and effectively. The specific aims of HEENE were to increase awareness of the NHS, the region, and to develop communicative skills.

6.3.4 Description of intervention

HEENE utilised the GMC content and implemented their own one-day induction, including more reference to local contexts and 'story-telling' from OMGs who had made a transition to the UK (see Box 5).

Box 5. Supporting Doctors New to UK Practice implemented by HEENE – September 2014 (recruitment for cohort 1)

Supporting Doctors New to UK Practice: Professional, Ethical and Cultural Development
25 September 2014

8.30 - 9.00 Registration and Refreshments
9.00 - 9.15 **What to Expect From Today?**
9.15 - 10.30 **Things I Wish I'd Known: Challenges and Concerns about Living and Working in UK**
10.30 - 10.45 Refreshment Break
10.45 - 11.45 **Overview of Good Medical Practice**
11.45 - 12.30 **Principles and Values of the NHS**

12.30 - 13.30 **Lunch & Networking** (All attendees and facilitators)
Lunch will be served during which delegates will network and receive information from external organisations, internal contacts, speakers and fellow delegates.

13.30 - 13.45 **The Newcastle Gateshead Initiative**
13.45 - 14.15 **Learning and Careers in the NHS**
14.15 - 15.00 **Working Relationships and Communication in the NHS**
15.00 - 15.15 Refreshment Break
15.15 - 15.45 **Developing Support Networks for Living and Working in the UK & What Next?**
15.45 - 16.00 Conclusion, Evaluation

The sessions were developed for sharing personal UK and NHS experiences, increasing insight into their own communication skills, obtaining linguistic techniques to improve communication, gaining transferable networking skills, developing awareness of the accents and dialects within the North-East and Cumbria, and raising understanding of coaching opportunities across the region. In future, they plan to develop their web-based resources for OMGs.

6.3.5 Intended demographics

The intervention targeted non-UK trained doctors and dentists who were new to UK practice or had begun UK practice in recent years. Doctors came from a variety of North East Trusts and were of varying specialties and levels. The induction was not offered to FY1 or FY2 training posts; only Trust grade doctors or those in higher training posts. At the 2014 induction there were 32 attendees and 10 no-shows. The intervention was needs based and engagement with activities were not mandated. HEENE did not run their induction in 2015 due to low numbers. However, 14 attended in 2016.

6.3.6 Potential facilitators and barriers

The GMC stated in their strategy plan that they had begun a high-level implementation plan, working towards implementing an intervention for all doctors entering UK practice[41]. As a

result, there were crucial content development and piloting stages. However, discussions highlighted that their 'products' lacked profile and dissemination of the information failed to reach many OMGs. This led to issues with recruitment. The GMC recognise the logistic and resource challenges in reaching OMGs. Due to fear of creating stigma, the GMC did not want to 'label' doctors by particular demographics and therefore did not wish to identify OMGs themselves. Trusts and deaneries also struggled to recruit doctors for the events directly. Therefore, the GMC provided promotional materials FOR the organisation. Information was also given in a 'Welcome to the Register' email and letter to all new doctors. Still, most of those attending the HEENE induction were unaware that the GMC offered an induction of their own. Dropout rates were also around 20%, despite three reminder emails. This was perhaps because inductions only took place in Belfast, Cardiff, Edinburgh and London, and many OMGs were unable to travel the distance or meet the cost. Those who organised the HEENE event also faced similar issues with recruitment and dropouts despite their best efforts to recruit. The HEENE induction was cancelled in 2015 due to low numbers. The fact that both inductions were free of charge may have led to further dropouts as no commitment was required.

Dissemination of available resources was also lacking between Trusts and regions, meaning effective tools were not being utilised by educators. Organisations instead seemed to be working in silo to address the same issues concerning OMG transition, without fully knowing whether their interventions were working. This also led to replication of both research and development activities. Many within the North East region (both trainers and trainees), for example, were unaware that there was a separate induction for OMGs who were on a General Practitioners training scheme. The silo working further illustrates how induction content and delivery is not standardised. Some individual Trusts are implementing their own inductions without any guidance or structure from the GMC.

The GMC invested considerable time in the evaluation and refinement of their intervention, however it did not explore how and why the intervention was successful (or not). Feedback was very much focused on satisfaction of content and delivery, and perceived learning outcomes. This was also the case with HEENE, who primarily collected feedback on future content. The GMC did however collect feedback from both attendees and observers. Nevertheless, if we were to look at Kirkpatrick's four levels of training evaluation model[294], only level one and two were addressed (satisfaction and learning).

The GMC stated that the highly interactive sessions were resource intensive and difficult to roll out on a larger scale, despite leading to high engagement and satisfaction. These were taken out in the refinement stage, however this led to a gap in terms of enabling the doctors to explore practical communication issues. Understanding effective communication was thought to be key in enabling a doctor to effectively transition to the UK. Findings from chapter 4 also illustrate that these sessions are often the most beneficial. This element of experiential learning was also lacking in the HEENE induction, which OMGs highlighted. However, HEENE do offer a separate communication course specific to the needs of OMGs (discussed in the next section of this Chapter). But again, OMGs do not seem to be aware that this is available.

The GMC induction itself was quite resource intensive to set up, therefore the GMC used internal facilitators to reduce cost. HEENE also did the same. The GMC stated that their three-hour induction session, which was cut down from the original full day pilot session, reflects the limited available time in education and training schedules across the UK. HEENE were able to provide a full day of induction. The GMC findings illustrated that there was support from organisations for such induction training. However, only around half felt that such a session could be part of their organisations induction or training programme. Again, this was likely due to limited resources and time.

HEENE has evidently taken ownership of the issue, rather than depend solely on the GMC. HEENE had a key figure who was passionate and enthusiastic about leading its implementation. The Postgraduate Dean was also in favour of developing the induction and considering key factors from this PhD that would drive success. The Dean stated that inductions for all doctors in training must have a HEENE (regional) element, however, there was consideration about ensuring a Trust based element. Engagement is likely to be dependent on the amount of OMGs in each organisation, which is highly variable.

OMGs who attended the GMC induction were able to have discussions, share experiences and relate to other OMGs, however attendees were generally from different parts of the country. In contrast, those who attended the HEENE induction were in much closer proximity and more likely to develop support networks.

6.4 Communication skills training for doctors new to UK practice (Health Education England North East) - Regional level

6.4.1 Description of site

Like the induction, this intervention took place in the centre of Newcastle so that it was accessible for OMGs throughout the North East.

6.4.2 Aims of developing the intervention

To increase OMG awareness of communication tools and develop their ability to effectively influence and interact in UK practice.

6.4.3 Description of intervention

Communication sessions were developed by the GMC following feedback that highlighted the need for OMGs to understand effective communication. This was seen as critical to enabling OMGs to effectively transition to UK practice. In response, HEENE developed their one-day communication course for OMGs.

The sessions were highly interactive and engaging. They included a great deal of pair work and group discussions. It was the ideal opportunity for OMGs to develop insight into their own communication style, obtain skills and techniques that could be implemented in everyday practice, and expand their awareness of differing communicative approaches. Reflection took place throughout the sessions. They were able to develop awareness of how personalities and behavioural styles effected communication barriers, and gain transferable networking, building rapport and influencing skills.

6.4.4 Intended demographics

Like the HEENE induction, the intervention was voluntary and information was sent to all education departments in all North East Trusts. Six participants attended; all varying in terms of levels, experiences in the UK, and training posts. All of the attendees were from hospitals in Newcastle.

6.4.5 Potential facilitators and barriers

The focus of the training was not on language, but concerned with OMGs knowing themselves and recognising how to communicate with their colleagues and patients. The enthusiastic trainers specialised in leadership and conflict resolution, and decided to focus on how OMGs could get the best out of themselves in the UK. They had focused on language,

tone, and pitch, in previous years, but they felt that understanding and being aware of British culture was more important for communication than learning specific language (which OMGs are expected to be adequate in). OMGs stated that this was highly beneficial: feeling more confident, motivated, and more aware of communication issues. They felt able to apply the strategies learnt to improve their practice, and even develop their own strategies in order to overcome difficulties in the future.

This intervention was voluntary, but OMGs had to pay a small fee to attend. This could have impacted upon recruitment. Many also stated that some of their colleagues wanted to attend, however supervisors would not allow their attendance due to high workload. This illustrates a lack of awareness within some organisations about the importance of such interventions. The fact that all attendees were from Newcastle also suggests that dissemination to other Trusts within the North East was low, or not a priority. It could also be that travel was an issue.

However, the low attendance resulted in small group training, which meant that specific needs were discussed and addressed. It also meant that there was interaction between all of the group members. It allowed for a safe environment where experiences and ideas could be shared. Specific feedback was also given from colleagues and peers about communication, including areas like body language. Like the induction, OMGs felt supported and respected by their opportunity to attend such an intervention. Many discussed their lack of social networks and feelings of isolation, so welcomed the opportunity to meet other OMGs. They felt they were not alone in facing such difficulties in practice, which also removed a sense of self-blame. A lot of those who attended did not have the opportunity to network with other OMGs. Many were also unaware that HEENE ran an induction, or arrived too late to attend it. This highlights a need for more interventions to take place throughout the year, also suggested by the GMC.

6.5 Comparative Trust sites

Whilst the focus of this project was to evaluate POD, the realist synthesis presented in Chapter 4 highlighted that there is much more outside of the training level to consider (particularly intervention implementation) when implementing interventions to support the transition of OMGs.

Through discussions with key figures implementing the GMC and HEENE interventions, it became apparent that although other Trusts within the region were keen to implement

interventions for OMGs at a local level, they were not able to do so. This became of interest to me in this project; looking at what created these barriers and explore the consequences of not having an intervention at the local level (discussed in more detail in Chapter 5). Each Trust had a context of its own, that was likely to either facilitate or create barriers to implementation. Although this may not be a typical element to a realist evaluation, it was felt that exploring these issues may shed light on crucial contextual factors for both development and implementation of interventions such as POD in the future. Looking at CMOs at different sites, where OMG transition was taking place, could develop the overall theory further. It was of interest to consider the impact of different interventions. What happens when OMGs are exposed to regional interventions but not local level interventions? What happens when exposed to no intervention? Can other contextual factors, identified in the synthesis, support transition despite a lack of training or support? It was hoped that answering such questions would guide future policy and determine if interventions like POD should be mandated within all Trusts.

Educators from the two case study sites, discussed below, made contact to discuss POD and find out how they could utilise the intervention in their own Trust. As mentioned, this has not yet been possible. The sites were visited and discussions took place with a variety of individuals. A background to the context and potential barriers are discussed below.

6.5.1 Clearwater Hospital

Clearwater Hospital (CH) provides adult mental health services and mental health services for older people. CH is made up of a number of self-contained ward units.

The geographical location seemed to hinder recruitment of OMGs, who prefer other locations in the North East. Psychiatry, as a speciality, already faces difficulties in filling posts. It was stated in a meeting that only 40% of their training posts were filled the previous year. Therefore, reliance was on OMGs to help overcome issues associated with these shortages. CH have actively travelled overseas (EU countries) to recruit doctors.

A number of meetings were attended with educators and medical directors from CH who were keen to develop their own interventions for OMGs. They felt strongly about the need to support their OMGs as they faced issues with both recruitment and retention of doctors that worked in their Trust. If they appoint OMGs to posts, they wanted to be able to keep them. It was believed that the only way to do that was through increased opportunities for training and support.

Through the many discussions, it seemed that the issues with implementation to date were due to the high staff shortages and lack of time. However, it seemed that realisation had led to the conclusion that initial investment of time would benefit overall. Staff shortages reduced the likelihood that a buddying scheme could be implemented.

Although POD could be used as a template for future implementation, it lacked focus on the specific medical knowledge that was needed for OMGs obtaining psychiatry posts. It has been stated on a number of occasions throughout this PhD that a lack of knowledge was unlikely to be the primary reason why OMGs face difficulties in their transition to the NHS, however with psychiatry this did not seem to be the case. Many OMGs were taking up psychiatry posts in order to obtain work within the UK, despite lacking essential knowledge and cultural awareness about mental health issues that arise in the UK.

6.5.2 Blossomvale Hospital

Blossomvale Hospital (BH) is a general hospital providing a 24-hour A&E service, a consultant-led maternity and special care baby unit, and a range of specialist clinical and outpatient services. The organisation has been in special measures since 2014 after the Care Quality Commission inspectors judged it to be failing to provide a sufficiently high level of care in a number of areas. Blossomvale is one of three Success Regime areas in England, where serious problems in the health and care system are being addressed in expedited programs set up by NHS England. Managerial support has been provided by another Trust. A campaign group is currently fighting to maintain hospital services at the BH, many of which have been moved to another hospital; 40 miles away.

Staff expressed feelings of being cut off from the rest of the North East due to the remote location. Location also highly influenced recruitment of UK graduates. Therefore, OMGs were highly relied upon in this area. However, many OMGs that moved to the UK did not expect to be working in such a location. Staff turnover was very high, including those at consultant level. BH relied heavily on locum doctors, who were expensive and only hindered retention further. Training posts were rare, therefore most OMGs were Trust Doctors. They were trying to introduce more Medical Training Initiative (MTI) posts, however funding was limited.

As with CH, BH wanted to improve the retention of OMGs in their Trusts. It was therefore important that BH was highlighted as a good place to work. Offering a greater level of support and training opportunities may attract OMGs to the Trust. Following involvement with the HEENE induction, engagement was sought by BH to discuss how they could begin the process

of implementing an intervention like POD within their Trust. They wished to find a way to fill the 'gap' and hoped to put a framework of interventions in place. Educators and medical directors that were involved in the meetings were aware that they had to improve the level of support that was offered to OMGs working there, particularly as they placed a great deal of reliance on them. No support or information was offered to them upon arrival. Furthermore, due to staff shortages, supervision was scarce.

Whilst visiting the hospital, discussions took place with seven OMGs that had recently started working there. After one year, all of them had left the Trust. Some had returned home and others had moved to cities in the UK. Through further discussions, it was evident that this was not just because of the area, but they felt unsupported and unhappy. During discussions, many locums stated that they did not think to look for support themselves and it had not been offered to them. Interventions like the HEENE induction exist, however dissemination to locations like BH may be lacking. As mentioned previously, travelling to Newcastle was an issue and high workload that meant time was not given for attendance. It was agreed in discussions with educators that hospitals like BH would benefit from local level implementation of interventions, and this would need the support of HEENE in terms of resources.

Discussions also took place with junior doctors who had graduated in the UK. As a result of the situation, they felt unsupported by senior OMGs that were new to UK practice, who essentially should be supporting them. Trainees were often supervised by long-term locum doctors, most from India and Pakistan, as they made up a high proportion of their staff. The junior doctors felt that they could not ask questions or instead felt that they were having to help them. There was a high reliance on junior doctors within the Trust. This perhaps reflects the lack of initial support given to OMGs, especially supervision. Even more importantly, this illustrates why patient safety issues may have been arising. Some OMGs have been removed from working.

A blame culture was also highlighted as an issue in the Trust. Educators felt that staff were blaming Trust Doctors for a lot of the problems. One individual stated that it was easier to complain about them than support them. It was also felt that Trust Doctors were an 'easy' target to complain about as they have no educational support at BH. It was stated that if foundation doctors were complained about in BH, the educational department would follow it up straight away and understand the issues. Trust Doctors did not get the same treatment.

Despite there being key figures, who were enthusiastic and striving for change, the staff shortages and lack of resources made implementing any interventions at that time near impossible. It was emphasised that, although it is recognised as a need, implementing a 5-day induction like POD was out of the question. OMGs needed an opportunity to explore the cultural differences, which was influenced by the rural location and older population. BH also had a lot of nurse practitioners who delivered the training to doctors. The importance of buddying and improved supervision was therefore emphasised.

6.6 Conclusion

Varied interventions are currently being offered to OMGs in the UK and it is unclear to what extent these are successful in supporting OMG transition. HEENE now recognise the need to develop regional interventions through their organisation and guide interventions locally in each Trust. It was suggested by educators from HEENE that a set of values and principles be developed for organisations employing OMGs in the North East and Cumbria. OMGs need to attend appropriate training, be exposed to educational opportunities, and build necessary social networks.

The comparative Trust sites represent an extreme illustration of differing contexts. This was not planned, but proved to be a beneficial learning opportunity since the two Trusts were struggling with implementation of interventions targeting their OMGs. This chapter begins to illustrate how organisations cannot simply replicate interventions like POD. CH struggles in recruiting doctors due to its unpopular specialty of psychiatry, whilst BH is in an unpopular location. BH also faces other issues that have impacted upon recruitment, implementation and overall morale. OMGs are therefore recruited to fill the shortage of doctors. Both hospitals also relied heavily on locums, who may not have the same needs as those in training posts. Those practicing psychiatry in CH will have differing needs and their interventions should reflect this. Without appropriate and adequate support, OMGs will be unable to provide the best care to patients and the current retention issues in these Trusts will not be resolved.

6.7 Chapter summary

The purpose of this chapter was to present the interventions and consider the context of each of the case study sites included in the evaluation. Differences between local level and regional level implementation were also highlighted. Since resources, staff and time are already short in the NHS, it is crucial that implementation is developed efficiently and intervention successes are highlighted. The discussion about each intervention are brief,

particularly POD, as detailed findings are presented in Chapters 7 and 8. It is now of interest to further explore the contextual factors presented in this chapter and present findings from the realist evaluation of POD.

Chapter 7 Findings from cohort 1: Programme theory development

7.1 Outline

The next two chapters discuss the findings of the realist evaluation of the Programme for Overseas Doctors (POD) at Amity Hospital (AH), including the exploration comparator case studies. Chapter 7 covers the findings from cohort 1 and Chapter 8 covers the findings from cohort 2. These chapters address the initial research aims of the project, which were to explore and evaluate an intervention to support the transition of Overseas Medical Graduates (OMGs) to the UK. Factors that facilitated and hindered success will be presented, further exploring the middle-range theories presented in Chapter 4 through the use of primary data. Developments for future implementation are also discussed.

This chapter begins by exploring post intervention outcomes of cohort 1 (POD1), including questionnaire data and performance data. Retention rates and career progression are explored for both the intervention group and comparator group. These are presented initially so that the outcomes can be drawn upon when discussing the programme theory. Overall findings, including interview data, are then presented. Each contextual level (organisational, training and individual) is discussed in turn. Context (C) – mechanism (M) – outcome (O) configurations (CMOcs) will be offered for each. The developed intervention is presented.

7.1.1 Summary of key findings presented in this chapter following synthesis of cohort 1 data

Due to the large amount of data presented in this chapter, a brief summary of the key messages are highlighted below:

- POD has benefited AH in terms of retention, career progression and performance of OMGs working there.
- The available resources and enthusiasts driving change at AH has enabled the intervention to be implemented with success. POD facilitated a supportive environment that fostered OMG learning and transfer into practice. The culture at AH ensured adequate and ongoing support was offered (alongside POD interventions). This level of support helped to overcome barriers identified at the

individual and organisational level. Being in such a culture benefited those at AH who were unable to attend POD.

- A lack of training and support at Blossomvale Hospital (BH) has hindered OMG retention and career progression. Evidence also suggests that OMG performance was hindered at BH.
- Training of OMGs has not been a priority at BH due to the issues discussed in Chapter 6. Despite having an enthusiastic individual and best efforts, severe staff shortages and a lack of resources meant that they failed to implement an intervention of any kind. OMGs working at BH believed that those who were supposed to be supporting them in their transition did not understand the adjustment they needed to make (work, interaction, cultural and general). OMGs have often arrived in BH with false expectations and disappointment.
- OMGs working in other hospitals faced similar issues to those at BH, despite attending regional interventions. OMGs noted a lack of support once they returned to their practice after the intervention. Training programmes alone did not facilitate an efficient transition. There is no evidence that regional and national interventions (such as those run by the GMC) effectively support OMG transition. They are unable to facilitate the necessary culture and ongoing support. Local level implementation is therefore thought to be more effective in supporting transition. Those at AH believed that POD should be mandated at the local level.

7.2 Quantitative data and outcomes

This section presents the quantitative outcomes of varying aspects of the intervention (including questionnaire data, performance data, retention rates and career progression). Due to the complexity of the intervention, these outcomes do not stand alone, but instead feed into the overarching programme theory. Exploration of outcomes through qualitative methods are not presented in this section, but are included in the presentation of the programme theory in section 7.3 (including the qualitative data collected from the questionnaires, researcher observations, discussions and interview data).

7.2.1 Questionnaire data

Results of the Wilcoxon Signed Ranks tests, including mean and standard deviation, are presented in Table 7. All mean scores increased post intervention. Although sample size was small and the findings were based on self-assessment, the findings highlight a significant difference in pre- and post intervention self-efficacy scores; $Z = -2.032$, $p = .042$. The mean

self-efficacy score for the group increased from 3.2 to 4.0 post intervention (5 being the highest possible score). This suggests that the POD sessions positively influenced perception of self-confidence levels (M).

Table 7. A table illustrating the mean scores (and standard deviation) and P values of the evaluation questionnaires given pre- and post- intervention in cohort 1 (n=7). All were assessed on 5-point Likert Scales, apart from the PPOS which uses a 6-point Likert scale

	Pre-POD	Post-POD	P value
Self-efficacy (good practice)	3.2 (.43)	4 (.21)	**.042***
Patient-Practitioner Orientation Scale (PPOS)	4.3 (.59)	4.8 (.48)	**.039***
Patient sharing (PPOS)	4.0 (.74)	4.6 (.63)	**.043***
Patient caring (PPOS)	4.7 (.53)	5.0 (.40)	.074
Culture	3.9 (.54)	4.1 (.36)	.416
Communication	3.2 (.52)	3.8 (.35)	.080

** = statistically significant p<.05*

Wilcoxon tests further highlighted that there was a significant difference in the self-assessed scores for pre- and post- intervention patient-centeredness scores; Z = -2.060, p = .039. Caution was taken not to generalise the findings as indications of improved knowledge and performance due to the self-assessment nature of the responses. The mean score for the group increased from 4.3 to 4.8 post intervention (the highest possible score being 6). This suggests that POD positively impacted upon perceived levels of patient-centeredness (PPOS) (M). There was a significant in difference for the sharing scale; Z = -2.023, p = .043. The mean score increased from 4.0 to 4.6. Caring scores were higher pre-POD in comparison to the sharing scores. This suggests OMGs had less understanding about ethical issues such as consent and confidentiality prior to POD.

It is interesting to note that the Wilcoxon test indicated that there were individual negative ranks (individual scores decreased post intervention) for culture, communication and the caring scale of patient-centeredness. This may be explained through an increase in

awareness and expectations for some participants (M). However, these did not impact upon overall mean scores. Prior to POD, these individuals may have genuinely felt that they could perform at a high standard and understood UK practice. Not all of the OMGs initially recognised the need for the training until they had practiced and trainers pointed out areas they needed to improve on (evidenced during researcher observations).

All trainees agreed that simulation was an effective tool, as illustrated through the questionnaire data (mean rating was 1.75 - agree). There was no significant difference between mean self-rating scores and mean observer rating scores. Neither of these scores were particularly high. This suggests OMGs were aware about good practice, of both themselves and their peers. The simulation sessions took place at the end of the training, therefore the scores suggests that self-awareness was evident by the end of the induction (M).

7.2.2 Performance data (Educational Governance data) (O)

Between August 2014 and July 2015, 204 incidents (see Figure 18 for types of incidents) were reported at AH (involving 126 individuals). Of these, 58 involved OMGs (36 individuals) and 147 incidents involved UK graduates (90 individuals). Further analysis from across the two years is presented in Chapter 8, which suggests that given the high number of OMGs in the Trust, there does not seem to be a difference here in OMG and UK graduate performance.

Five incidents involved those that attended POD (four individuals). This number is small (11.4%) considering a total of 35 OMGs attended a POD intervention prior to July 2015. Thirty OMGs entered the Trust after POD ran in August 2014, therefore were unable to attend. Eight of these individuals were reported to be involved in incidents (26.7%). Differences could not be explored between POD and non-POD attendees due to the small sample size.

As Figure 18 shows, OMGs that attended POD were involved in three different types of incidents. Two of these incidents were Serious Untoward Incidents (SUIs). Upon deeper investigation, one included a misdiagnosis and the other involved the deterioration of a patient. The latter was not deemed to be the fault of the OMG. There were also two datix incidents; one was a due to lack of documentation and the other was due to the incorrect method of taking blood. The final incident included a complaint from a patient who felt they were inappropriately discharged. However, it stated in the notes that their supervisor felt it was appropriate. Ultimately, out of the five incidents, three were thought to be the fault of the OMG. These practical and procedural issues needed to be addressed in practice. OMGs

that did not attend POD were involved in nearly all types of incidents (see Figure 18), including SUIs.

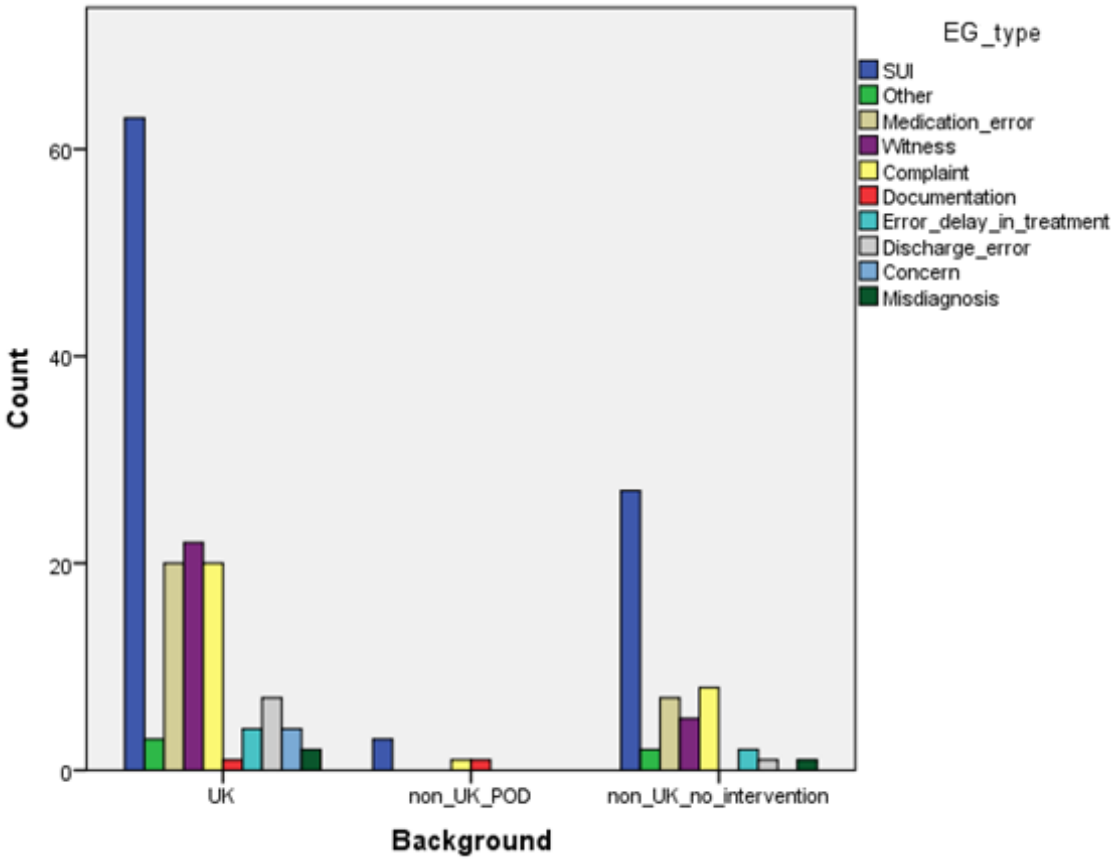


Figure 18. Graph showing the types of incidents that were reported between August 2014 and July 2015 in accordance with the Educational Governance data (EG)

7.2.3 Retention rates and career progression post intervention (O)

Table 8 illustrates that retention rate for those that attended POD was high (after one year). Those individuals that left the hospital did so due to personal circumstances or to develop their career in another Trust. All but one of the OMGs in this group had progressed in their careers (or were in the process of applying). The majority of OMGs were successful in their examinations. One individual had difficulty in getting get some competencies checked off during the final months of their foundation training, however the OMG was supported by their supervisor to do so at a later date. The individual was not adversely affected by these difficulties as they secured a place on a GP training scheme.

Table 8. Table showing career progression and retention rates of OMGs from AH one year after POD (cohort 1)

Cohort 1 – Intervention AH		
Grade started at	Retention after 1 year	Grade after one year
Foundation year 1	Remain at AH	Foundation year 2
Foundation year 1	Remain at AH	Foundation year 2
Foundation year 1	Left due to personal circumstances	N/A
Foundation year 2	Remain at AH	Applying for Specialty Training
Foundation year 2	Stayed to finish competencies not completed	Starting GP training scheme in another Trust
Foundation year 2	Left due to obtaining training post	Left to start Specialty in another Trust
Trust Doctor	Left due to family circumstances at home	N/A
Trust doctor	Remain at AH	Specialty Training
Trust Doctor	Remain at AH	Core Training
Trust Doctor	Remain at AH	Specialty Training
Specialist doctor	Remain at AH	Specialist doctor
Medical Training Initiative	Remain at AH	Registrar
Clinical Fellow	Remain at AH	Clinical Fellow applying for Specialty Training

Table 9 illustrates that retention rates of those in the comparator group was much lower than those who attended POD. However, this is inferred as the sample sizes were too small to run analyses. It is interesting to note that despite having no intervention, those recruited from AH remained working in the hospital and progressed in their career, or left the hospital to take up another career opportunity.

Table 9. Table showing career progression and retention rates of OMGs from comparator group one year after POD (cohort 1)

Cohort 1 – Comparator group			
Grade started at	Recruited from	Retention after 1 year	Grade after one year
Foundation Year 1	HEENE (com)	Remain at Trust	Foundation Year 2
Foundation Year 1	HEENE (WtUKP)	Remain at Trust	Foundation Year 2
Foundation Year 2	AH	Remain at AH	GP Specialty Training
Trust Doctor	BH	Left BH to go to America	N/A
Trust Doctor	BH	Left BH to return home	N/A
Trust Doctor	HEENE (com)	Left Trust	N/A
Trust Doctor	HEENE (WtUKP)	Left Trust	N/A
Trust Doctor	HEENE (WtUKP)	Left Trust to start in another Trust	Trust Doctor
Trust Doctor	AH	Left AH to start Specialty Training	Specialty Training
Trust Doctor	AH	Remain at AH	Registrar
Specialty Training	AH	Remain at AH	Specialty Training
Clinical Fellow	HEENE (com)	Remain at Trust	Clinical Fellow

This section highlights that the initial training outcomes of POD1 were positive (although the small population size and use of self-assessment tool limits generalisation). Performance data for all OMGs at AH did not highlight any concern, regardless of whether OMGs attended POD or not. Retention rates and career progression of those who attended POD at AH, as well as those that did not, were high. OMGs from comparator hospitals illustrated poorer retention and career progression (again, not to be generalised due to small sample populations). These outcomes fed into the programme theory presented next.

7.3 Programme theory development - synthesis of findings

This section presents a synthesis of the findings from cohort 1. Table 10 highlights the demographic data of all interview participant groups. As is evident, there is a varied mix of grades, gender and place of graduation (including both international and EEA).

Table 10. Participant demographics and sample size for cohort 1

Cohort 1 (POD1)	OMG intervention	Supervisors	'Buddies'	OMG comparator
Gender	Female – 8 Male - 5	Female – 6 Male - 14	Female – 2 Male - 2	Female – 3 Male - 9
Grade	Foundation training (6) Trust Doctor (4) Specialist Doctor (1) MTI (1) Clinical fellow (1)	N/A	N/A	Foundation training (3) Trust Doctor (7) Specialty training (1) Clinical fellow (1)
Country where graduated	Italy (1) Pakistan (3) India (2) Romania (2) Spain (1) Sri Lanka (2) Poland (2)	UK (5) Non-UK (15)	UK	Egypt (3) Greece (2) Sri Lanka (1) Pakistan (2) Italy (1) Nigeria (1) Spain (1) India (1)

Quotes from interviews with the first cohort of OMGs that attended POD are denoted as [*OMGX*_POD1]. Supervisors are denoted as [Supervisor_OMG*X*_POD1]. As both educational and clinical supervisors were recruited, the second supervisor is presented as [Supervisor2_*OMGX*_POD1]. For most, the clinical and educational supervisor was the same during the first three months. Those not in full training posts only had a clinical supervisor. The number stated after 'OMG' links the supervisor to the OMG. Interviews with 'buddies' are denoted as [Buddy_*OMGX*_POD1]. Again, the number after 'OMG' links the 'buddy' to the OMG. Those who did not attend POD are denoted as [*OMGX*_NON]. For all groups of participants, 'Int2' represents the follow up interview.

Instead of presenting the findings for each participant group that took part in interviews, data for each group was analysed together and fed into the overarching programme theory.

No reference is made to which hospital the OMG was from or whether they have attended a GMC or HEENE intervention. It was felt that these details were not needed and protected

anonymity, the key factor being whether the OMG had attended POD or not. Where the findings benefitted from extra information, it was discussed in the relevant context.

Prior, emergent and analytic themes have been identified. Prior themes identified from the realist synthesis were used to guide data collection and therefore those that are highlighted as prior were themes that confirmed the initial programme theory. Those identified as emergent themes were themes that were identified in the data but had not been asked about. As themes emerged, these fed into the data collection process in order to test them within the programme theory. Analytic themes were evident throughout all of data analysis due to the nature of the realist approach and development of CMOcs. Analysis involved seeing how the CMOs fit together with the primary data and therefore required inference beyond the data. Emergent and analytic theory was identified to test and refine the CMOcs.

A summary of the developed contextual sub-themes identified in the programme theory is presented in Figure 19.

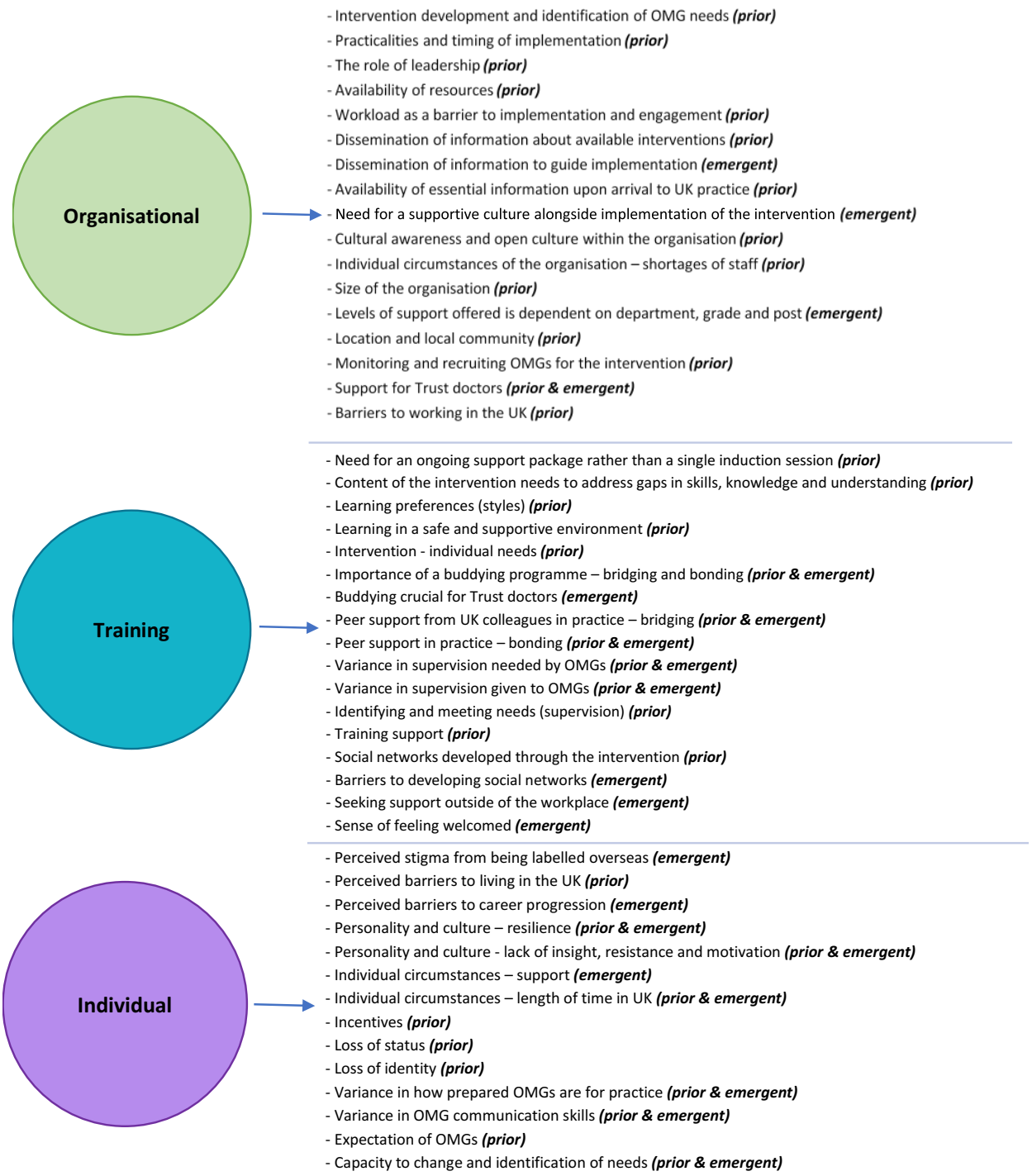


Figure 19. A summary of prior and emergent contextual sub-themes that were developed from cohort 1 findings. Analytic themes were evident at all levels (due to C-M-O configurations being developed).

7.3.1 Organisational context

Organisational level context refers to factors outside of the intervention itself. These factors cannot be controlled at the training level, but instead guide intervention implementation and can either facilitate or hinder the training efforts. The factors that were found to impact upon intervention success are presented in turn.

7.3.1.1 Intervention development and leadership

Intervention development and identification of OMG needs:

POD was refined as a result of the initial findings presented in Chapter 4. Development also resulted from researcher observations, discussions with OMGs and educators, and POD planning meetings. Ultimately, a great deal of time and investment went into development (C). This PhD was funded by a North East NHS Foundation Trust to evaluate the intervention, therefore was not a 'tick box' intervention and evaluation. It was important to key stakeholders to fully understand if the intervention worked, or not, and how. This was particularly true given that OMGs are reported to have complex and ongoing needs.

Although it may seem a self-evident statement to make, developing an intervention that addressed OMG needs was crucial (C):

> *It was for new NHS people. It was only for one day. To be honest, it was not enough. I didn't think it was enough at that point. [OMG2_NON]*

> *I appeared in the department and just the consultant told me to follow him around his visit and it was like repeating what I was doing as a student, following the professional doing his visit and this is not helpful for somebody coming to a new place for work…[OMG9_NON]*

The individuals above clearly expressed that their needs were not addressed or necessarily understood. One OMG from AH who had worked at another Trust stated:

> *…the initiation period was very short and not really gradual and there was no support at all. It's one thing if you tell me one, two, three, four, but 20 things in all at one go, I obviously am not going to retain all of that, isn't it? If I could have performed better, I would have been of more use, and less feathers would have been ruffled. [OMG2_POD1]*

These initial negative feelings reduced engagement with the induction offered (M). Poor induction may have hindered performance (O).

In contrast, POD at AH was well received by OMGs (M):

> *…it was useful and I really want to thank the Professor for sorting this thing out, because nowhere they do this overseas doctor thing. They start working and after a few years obviously you get to know things, but you do struggle a bit. It takes a really long time, so that was really useful for us. [OMG6_POD1]*

It was crucial that OMGs saw the need for POD so that they were willing to invest their time in attending (M) (often using their study leave):

> *It depends on the time constraint, you know, whether they're allowed to do these days or five days of study leave for this course, you're only given 10 days in the year for the study leave, so I don't want that to be like kind of taken off from that. If we can cover the main topics and main things what we need to cover, then that would be fine. [OMG11_POD1]*

In contrast to POD, where support for the intervention was growing within the Trust, HEENE was struggling to recruit OMGs to attend their interventions. Their induction had to be cancelled on three occasions due to low numbers. This highlights issues with implementing interventions at a regional level, OMGs are more likely to engage with local level interventions like POD (M). Interventions on a local level also enabled the formation of social networks (discussed later at training level). However, discussions with policy makers and key stakeholders suggested that there is a need for regional input; to put structure and guidance in place.

The fear of creating a sense of stigma through an intervention specific to OMGs was raised in many discussions at AH and HEENE:

> *Even though lots of the research suggests that this is what they need, this is what they want, actually I think sometimes they feel like you're saying you're not good at something. And I mean I suppose in a way you are saying that, you're saying well these areas you need to develop, we know these are common areas that overseas doctors struggle with, but actually engaging them on the programme I think has had some challenges. [Supervisor_OMG4_POD1]*

> *You target people who you thought would best benefit, and then there's a bit of well why have I been asked to go when I know that person hasn't been asked? [Supervisor_OMG8_POD1]*

This sense of stigma is certainly a point of importance, however OMGs were appreciative of the opportunity to engage in the intervention (C), likely increasing their commitment to the organisation (M) (also discussed with educators in comparator Trusts) and facilitating overall retention (O) (illustrated in Table 8):

I think people here are very helpful. This is one of the best programmes that you could have. [OMG2_POD1]

I think from the overseas doctors' perspective it's, people offer you training when you come here. It's actually, it's almost like making you feel, well accepted, making you feel that they've thought ahead, that there's a place for you. And it's like this is what we expect, this is. [OMG9_POD1_INT2]

All of those who did not participate in an intervention stated that they would have liked to. 'Throwing them in the deep-end' (taken from discussion at CH) negatively impacted performance and patient safety (O):

I had no UK experience, none of the consultants knew and none of the other colleagues knew, so I was given on-call bleep on the first day, had no clue whatsoever, and there were like eight patients to clerk. (OMG3_NON)

I appeared the first day at the hospital and they told me, oh you know, you have an on-call shift until nine thirty, without even knowing where is the ward that I had to be and I had to be at an emergency without knowing how you request things, because it was a different hospital, nothing. And I did consecutive six days of on-call shifts in the first week that I appeared. This is absurd! You know, it is like going to a new place and that you have to treat lives and you don't know nothing and they tell you, you are responsible for everything. [OMG9_NON]

The lack of integration period before OMGs started work could have been dangerous. Interventions needed to be in place to prevent incidents (O), rather than providing support and training once 'mistakes' had been identified:

I wasn't aware of this thing until like I made a mistake, and yeah. [OMG11_NON]

POD intended to prevent incidents:

…that programme [POD] kind of helped address some of those issues. So they were quite good at picking up on what I might be struggling with. [OMG4_POD1]

The findings suggest that POD1 was successful in identifying relevant needs (see individual needs in section 7.3.2.3).

Practicalities and timing of implementation:

Practicalities of developing such complex interventions hindered the success of POD1 (C):

…practicalities are such a huge barrier to it…that includes releasing them to do it…logistically it's just really difficult. I mean the programme was late this year, and I think that was negative. [Supervisor_OMG4_POD1]

As mentioned above, timing of implementation (C) was a key factor for learning and engagement with the intervention (M). OMGs noted that if the intervention was too early, it would not have been as beneficial:

> *I was still in the phase where I needed to do that. But at that point I sort of had gotten over the initial culture shock of moving to a new place and getting used to how things work in a new place, just like, yeah, just how the system works and how things work…If I had done that course immediately before, it would have been a further sort of mound of information and knowledge to intake and sort of adapt to…a) they're already here and they have to be here, and then (b) sort of they've had a few weeks to adjust, and may have questions that have arisen immediately, saying like oh this happened to me, I don't know why, I don't know why this interaction went the way it went. [OMG9_POD1]*

However, timing (C) was one of the main reasons why those from AH did not engage (M) fully with buddying and the peer support group, despite having requested them. In many cases the offer of buddying came too late to be of use to the OMGs:

> *…we might have been more successful with the buddying if we'd started earlier. [Supervisor_OMG4_POD1]*

> *…you look for your own mentors don't you and your own support…you sort of instinctively do that, which is what I think the doctors have already done because they've been there for six months before, or four months or whatever sorry before we've met them, they've made that, because you have to. [Buddy_OMG2_POD1]*

Despite my suggestion that buddying and peer support should be in place as soon as OMGs arrived in the workplace, it was not possible due to the complex recruitment system (see context of the work environment in section 7.3.1.5). Buddying was instead implemented as part of the POD induction. 'Buddies' were also recruited last minute, without much exploration of individual needs.

The Director of Education at AH was fairly resistant to the idea of a buddying system to begin with. It was felt that buddying had never worked in the past. OMGs also noted this:

> *And that's why buddying is not practical. It is ideal, to be honest. But for the employer it's not practical, you know. So employers will discourage it. [OMG6_NON]*

Due to this initial lack of enthusiasm for buddying, less thought was given to the practicalities, such as timing and proximity. Had it been given more attention, the impact was likely to have been greater. It was suggested that buddying should complement POD:

…you need three or four systems in…different people will access and get support from different ones. [Supervisor_OMG4_POD1]

Each component of the intervention represents one of a few 'safety nets', rather than being stand-alone interventions. This would help to overcome the timing issues discussed.

The role of leadership:

Leadership was found to be crucial to intervention development and sustainability (C). Discussions with key stakeholders and educators at AH highlighted the need to gather support when they were implementing POD, as it required a driving force and ongoing enthusiasm:

Whilst these things are great, the first couple of, two times you do it, and then you've then got to do it for the next God knows how many years. And finding somebody to do that with enthusiasm is, it is challenging. [Supervisor_OMG6_POD1]

I think in actually delivering the programme, you know, as with all of these things this has been enthusiasts, myself, and people who've been really enthusiastic to get it to happen. [Supervisor_OMG4_POD1]

It took strong leadership to not only implement the intervention, but to strive for long-term changes and sustain them. The responsibility was taken on by the Director of Education at AH who led the POD planning team. The team consisted of key figures who pushed for change within the Trust. It was recognised that OMG transition was not a 'quick fix'. This effort led to increased satisfaction of OMGs (M) and likely impacted upon retention (O).

Although BH had a key figure driving for similar changes to the way they supported OMG transition, they faced many challenges. The Director of Education wished to develop a clear strategy to induct, support and develop any doctors that moved to BH. However, due to contextual factors discussed in Chapter 6 (and in the next few sections of this chapter), they were unable to implement any form of intervention. Support was needed from others within the Trust, not just from one individual (C). Satisfaction of OMGs therefore remained low (M) which hindered retention (O) (see Table 9).

This section highlights the importance of intervention development and leadership in ensuring interventions are implemented adequately, supporting the findings from Chapter 4. Practicality issues, such as timing of the intervention, hindered POD from being entirely successful.

7.3.1.2 Resources and workload

Availability of resources:

The findings from the realist synthesis placed much emphasis on the need for ongoing support and a rigorous induction at the local level, however this is not possible for all Trusts due to lack of resources (C). As a result, interventions may not address OMG needs and will likely reduce engagement (M). Where resources were limited, interventions were either minimal or failed to be implemented at all (evidenced by comparator data). Regional support and pooling of resources is therefore crucial to ensure that training is readily available to fill gaps. If interventions like POD increase performance and improve retention (as expected) (O), these outcomes should outweigh the costs of implementation.

The use of external trainers was a costly resource for AH, particularly as they doubled in price following the pilot intervention. Although they were language specialists that provided in depth communication skills, the expense of implementation meant that their input was unlikely to be sustainable. It was also highly unlikely that other Trusts, given the contextual backgrounds discussed in Chapter 6, would be able to source funding. The initial purpose of an external group was to utilise their expertise and availability.

Discussions with OMGs identified the need for support in other areas, however these would require significant resources and so could not be addressed (C) (for example accommodation):

> *…now most of the hospitals don't have the hospital accommodations, so they are being always advised to stay in a rented accommodation which is away from the hospital. I have seen two or three where they felt really isolated. I have seen one or two who really were down emotionally and as such it is very stressful anyway to come to a complete new culture…they sort of mulled over what, and they [the Trust] agreed that probably this is a genuine problem, but we don't have a solution because obviously the Trust is looking to save the money. [Supervisor_OMG2_POD1_INT2]*

If these resources had been available, initial satisfaction, stress levels and overall commitment may have increased (M), impacting both cultural and general adjustment (O).

Workload as a barrier to implementation and engagement:

Workload (C) impacted upon OMG engagement with POD and the transfer of their learning into practice (M):

I actually didn't attend it properly, because I was supposed to attend but then I had to go back to the unit. I didn't get an opportunity afterwards because of my duties, but I thought I would have really benefited if I would have gone to it. [OMG4_NON]

It was also recognised that five consecutive days of training was too much given high workload (C) and resulting stress (M) (for trainers, colleagues and OMGs):

So there is work to be done, and that person is expected to do work, and if you are then taking them out doing a course or doing stuff, then who's doing the work? And that puts stress on the other members of the team, people who are on call, on nights, it can be quite stressful. [Supervisor_OMG9_POD1]

To increase engagement (M), it was decided that future POD would be implemented one day a week across a number of weeks. The benefits of POD for OMG work adjustment (O) were thought to outweigh costs of releasing individuals from wards, however, where workload was extremely high, this was sometimes an unachievable task:

…obviously that means the Trust is paying for it, if we're having our 50% overseas graduates then who's going to do the work that week? On the other hand, you do it then, you stop someone floundering for the next couple of months. [Supervisor_OMG9_POD1].

I am working alone, covering about 12 wards with like about 150 patients on my own. [OMG7_NON_INT2]

Workload (C) also impacted upon engagement with the buddying component of POD (M):

We've have been planning to meet up and it's just not happened, one of us has been busy or whatever. [Buddy_OMG14_POD1]

We tried to get in touch with each other, seeing each other after the teaching session, because she's an F2 as well. So when I attended the teaching she couldn't attend, she was on call. When she attended I couldn't make it, so basically we didn't actually meet at all. [OMG7_POD1]

Due to limited resources and workload (C), neither the buddying or peer support sessions were implemented in the most effective way, for example, 'buddies' were not given any formal training due to limited time. The lack of formal structure and implementation could perhaps be one reason why neither party fully engaged in the buddying process (M). Through later discussions, it became apparent that the timings of the groups were not suitable, despite different time-points being trialled. As attendance was voluntary, busy wards took top priority over these informal meetings:

…there's no point putting stress when somebody's already stressed. [Supervisor_OMG9_POD1]

Nobody showed up to those meetings because everybody's just busy and nobody wants to show up to those things. [OMG8_POD1]

Confidence in the organisation decreased where initial support was not offered due to high workload (M):

I think like when those induction courses came to an end, for some reasons they were stopped, I felt very sad about it…international doctors were going to lose out in not having that introduction to the NHS. You were just going to be left on the shop floor basically just to grab what was delivered to you. [OMG1_NON]

… they don't care, they are very stressed by the lack of staff, so they just don't care. They see you as somebody that comes for the money. [OMG9_NON]

Interventions like POD cannot always be attended prior to starting work, but as previously stated, other support and safety nets should be offered upon arrival, such as buddying.

The impact of resources on intervention success was highlighted in the initial theory. The data presented here emphasised the impact of workload alongside this.

7.3.1.3 Dissemination and information

Dissemination of information about available interventions:

OMGs need to be aware of available interventions (C) so that they can engage in them (M). This may seem like an obvious factor to consider when implementing interventions, however discussions revealed that this was very much lacking. This was particularly evident for those that attended the regional HEENE programmes:

I think there are many advantages in the Trust I don't know anything about, like the course which I applied, which I attended I just know it by chance. I have been here for six months looking for these courses and I got it just by chance. [OMG7_NON]

Even within the local context at AH, awareness of POD was low. Some OMGs never got an invite to POD. Information was also given too late at times (due to recruitment issues discussed in barriers in section 7.3.1.6) (C), which hindered engagement with the support offered (M):

I said, what, now? You want to do training and teach me how to run around the hospital after a year, I think I already know that. [OMG7_POD1_INT2]

Dissemination of POD, both within the Trust and outside the Trust, was highlighted as important during the POD planning meetings at AH (C). This not only led to increased engagement from OMGs themselves, but engagement from other key figures, policy makers, and quite importantly supervisors who can encourage OMGs to attend (M):

> *I don't think it was my idea to send him on the programme, but I think it was in the education department had this going on, and it's like I think that's a good idea. I think it's something that I would, I know I would use now because I know we've had some anecdotal reports of how useful it's been. So I think if I was faced with a student like him now I would encourage him to go on that. [Supervisor_OMG9_POD1]*

This spreading of good practice and support from all levels is needed for such interventions to continue to be funded, developed and sustained.

Dissemination of information to guide implementation:

Dissemination of the findings from this evaluation research was also highlighted as a necessity, given the complexity of the three contextual levels presented. As the realist synthesis illustrated, a range of different interventions have been tried, but without a clear understanding as to how they work, or who they work for, many even failing to conduct any evaluation. Educators and policy makers who implement interventions to support the transition of OMGs are seeking to address the same issues, therefore it would be both cost- and time-effective to share findings so that they can do so in the best way possible. Initially, the POD planning team were hesitant about sharing findings from POD1 with others. They did not want to share the intervention at this stage as a) the evaluation was incomplete and b) they did not fully understand how it worked, therefore other Trusts could not use the findings to aid development. On reflection this was a good decision as the intervention changed much over this time. The choice that AH took in waiting for a refined version to be developed before dissemination illustrates their investment in POD and the importance of evaluation (intervention development).

Availability of essential information upon arrival to UK practice:

Information to support OMG transition (O) was needed before, or at the least upon arrival of the OMG (C):

> *…like for example from the first time to work in the UK you have a package of support, like contact this, contact this. It's just a single paper or a single email from my Trust email would solve many problems. [OMG7_NON]*

When information was lacking, satisfaction and confidence in the organisation decreased (M):

> *I was quite enthusiastic about working here, but then, and I found it difficult to know about exact working before, prior to coming here, doing your homework as to what, because people don't really tell you what is it like working here. And I felt the need of being supported initially, which I did not get. [OMG2_POD1]*

Even when OMGs pushed for initial information and pro-actively tried to ease their transition, they were not always successful in accessing information:

> *I had one friend that told me that it should be easier for me to come one week before and to go to the hospital and introduce myself and just have this week of induction informally, so that I would make a better impression to them. I came here one week before, but the locum agency did not know exactly at which department I would be. I made a lot of questions and they found the final day, so I could not appear. [OMG9_NON]*

OMGs in BH raised concerns about the lack of information regarding supervisor support, even months after working in the Trust. This experience was not unique to BH, OMGs from other Trusts had faced similar issues:

> *I didn't know who was my clinical supervisor until at the end of my job [OMG11_NON]*

Without necessary support and much needed information (C), knowledge and understanding about practice was hindered (M), impacting upon performance (O):

> *But it was always difficult how to get a blood done. So I know how to take out blood, but which forms to do, what not to do, things like that, Trust policies. [OMG10_POD1]*

This is evidenced in the performance data (section 7.2.2) – an incident was reported against an OMG that attended POD due to their unawareness about documentation procedures. Leadership and early support could have helped avoid this incident.

This section illustrates that dissemination and availability of crucial information were key themes arising from the data.

7.3.1.4 Organisational culture

Need for a supportive culture alongside implementation of the intervention:

The support that was offered to, and perceived by, OMGs was very much facilitated by the overarching culture of the organisation. This was a key factor highlighted in the initial theory.

A rigorous intervention like POD is beneficial to OMG transition, however organisational culture (C) must facilitate transition alongside implementation:

> *…it's a very good seed that can only bear fruit if the ground is well prepared for it. [OMG6_NON]*

OMGs at AH, both those who attended POD and those who did not, perceived a supportive culture in the hospital. As a result, satisfaction with their work and commitment to the organisation increased (M) (also supported in the questionnaire):

> *[Amity] was a much friendlier place. I found it more welcoming, the people are more supportive, more tolerating. I felt more comfortable here…50% of the consultants and doctors are of course UK/British trainees, more than 50% definitely, but a good number is overseas trainees…you find different people from different cultural backgrounds. [OMG2_NON_INT2]*

As illustrated above, the variety of cultural backgrounds at AH increased levels of self-esteem and reduced the likelihood that OMGs would feel alienated (M).

> *I've learned how to ask for help in a better way in a sort of way so to speak, if that makes any sense, I don't know. You're not so hesitant to be like oh s**t, I don't know what I'm doing, I don't want to ask the question. [OMG4_POD1_INT2]*

The acceptance of OMG learning needs (discussed in intervention development) was important, but without creating a sense of stigma or prejudice (C):

> *Because if you go into the GMC, majority of the doctors who are complained against are non-local non-natives. [OMG6_NON]*

It was important that supervisors identified and handled vulnerabilities sensitively, seeking to increase OMG Cultural Health Capital (wellbeing, resources, resilience, optimism) (M) and improve performance (O):

> *I think actually the support that [Amity] offers seems to be a lot in comparison to other trusts. Which is a bit frightening. I think she had, it started in Newcastle, that because they were expecting because she was senior, you know, they were expecting her to work at a consultant level, and I think there was some issue... I think there was some clinical incident which some of the colleagues were unhappy about. So they demoted her to first on-call… [Supervisor_OMG6_POD1]*

Stress increased and self-esteem was hindered when issues were not handled in a sensitive manner (M), leading to poor retention (O):

…of course this was stressful for me not to be able to … to have, being the disgrace of my consultant, that he did not want to understand my difficulties. [OMG9_NON]

Perceived racism was much more of an issue in some Trusts, impacting upon feelings of alienation, self-esteem and satisfaction (M):

Big racism - I was surprised by that, by this impression that I have now, but this is true. I thought that coming to the UK, it's supposed to be a country that has populations from many nations from all over the world...I thought that I would feel comfortable. But on the other hand I felt very disappointed, frustrated, and I had very cold and very cruel behaviour and acceptance from the hospital…You know, all these things are that every time I had to wake up and go to the work it was not the best experience that I had. It was like a nightmare. I didn't know what to expect. Nobody was saying good morning to me, I don't know why, and I said good morning, nobody answered and it was like, I don't know, the bad foreigner, the bad Arabic guy, I don't know, because when they see that you are a dark colour. [OMG9_NON]

Most colleagues and supervisors at AH recognised that OMGs brought important medical knowledge based on their prior experiences (C):

I think they're a really valuable addition to medical training and medical experience for doctors and learning, and I guess for the patients also…I guess you have to just say that's their way of doing that. And I think we should value it, and we value them. [Supervisor_OMG9_POD1]

Feeling valued led to greater satisfaction and reduced the likelihood of feelings of alienation (M). This would have a positive impact on work and general adjustment (O).

Cultural awareness and open culture within the organisation:

The support and cultural awareness of colleagues and supervisors, illustrated above (discussed in more detail in peer support; section 7.3.2.4), was largely determined by the organisational culture. A lack of support impacted stress levels (M) and raised interaction and performance issues (O).

OMGs at AH largely noted that acceptance, support and awareness were evident amongst their colleagues (C). This impacted upon satisfaction levels and commitment to the Trust (M), leading to increased retention (O) (also evidenced in retention data):

I think I'm lucky enough that in this hospital consultants and other people and everyone, you guys, nurses, everyone's quite sympathetic and empathic towards us, like they're nice. Where I feel like maybe in other areas people are a lot more demanding and have a lot higher expectations, don't care about your background, and stuff needs to be done and they don't have time. So in that case I think it would

be a bit more overwhelming if I got like scolded one too many times for not doing something. Then I'd feel like I would come home like contemplating whether I did the right thing moving here. But I didn't really think that because there's enough support and encouragement here. People know that I didn't qualify here…they don't mind it when I ask them a little bit more questions basically. [OMG4_POD1]

…consultants throughout, and colleagues are very supportive…that's why I continued my training here. [OMG11_NON]

The open culture led to OMGs feeling confident in asking questions, ultimately impacting upon their Cultural Health Capital and understanding of working in the UK (M). This would ultimately impact upon performance and patient safety (O).

OMGs from comparator Trusts illustrated that a lack of awareness from colleagues impacted Cultural Health Capital, particularly optimism and resources (M). Reduced satisfaction and self-esteem, and increased alienation were also evident (M):

I found that it's very important that the people who you are going to work with are aware of your likely difficulties or what you are going to face and are open about and accepting about it, and at least in the last place I worked it was not, I didn't feel that. So that kind of in a way it puts you down or makes you feel sad because you have left your comfort zone and you are coming somewhere else and you need some support. [OMG2_POD1]

…there were many times for example I felt really bad and unwelcomed, because I was supposed to work in the first month as a registrar and there were a lot of junior doctors that because they saw that I did not know the system they were not, how to say it, they were not there for me…when I asked something they tried to find ways not to do it. [OMG9_NON]

If UK colleagues are not aware of cultural differences, unfamiliarity and the challenges that face OMGs, it may appear that their OMG colleagues are not competent to practice (inappropriate complaints evidenced in section 7.2.2). Complaints could be detrimental to self-esteem (M) and impact upon OMG wellbeing and retention (O):

I think possibly if you were unaware it could make you believe that somebody was less clinically able than they actually are. [Buddy_OMG9_POD1]

I mean obviously there's a lot of issues of trust I suppose with teams. And when they see that you don't seem to know what you're doing, which is not the case but with these particular conditions, then they lose trust and it all becomes very stressful. [Supervisor_OMG13_POD1]

In terms of performance I had complaints by the colleagues and for example I was, because I had all of these difficulties to understand how, you know, it was like a chaos

to me. I did not know, I just knew how to examine the patient and whatever I wanted to do I did not know if it would be correct or wrong. [OMG9_NON]

When discussing the subject with UK graduate foundation doctors at BH, they stated that they felt unsure whether to ask senior OMGs for advice as they felt that they may not practice the right way and teach them wrong things. This lack of awareness will likely lead to a longer adjustment process as described below (O):

British trained doctors or people who are in positions of leadership like consultants etc. really don't understand the amount or the degree of adjustment that international doctors have to make. You know, and all the way from weather to culture to communication, to things like loneliness and the fact that you're just away from home, and you're maybe away from all your loved ones, to the fact that you're now struggling to understand illnesses, because there are some things that in my country are just not common, like irritable bowel syndrome…unlike here where it's quite a common diagnosis. So it's a whole change really, and they are not always supportive to help settle into it, and having that support put from the clinical team you work with, and probably from your friends or whatever, just makes a whole lot of difference to how well you get on really. [OMG1_NON]

The awareness of the supervisors and their attitudes helped to educate UK colleagues:

Well we talked to them about the need to support, and we put in, I was supervising one of the FY2s and I said right I want you specifically to go and support this guy, because he's struggling with this and he needs support to get through it, you know, it's not that he's a bad doctor. [Supervisor_OMG4_POD1]

I'm really telling myself to be aware of, yes, this is a very junior doctor coming from a very very different environment into here, as to what extent he or she is actually happy or familiar with the environment…raise awareness in everybody. [Supervisor_OMG11_POD1]

Education and career support:

AH recognised the importance of OMGs in their Trust, offering a high number of training posts (C):

I mean for us in the Trust they're really valuable. We have lots of overseas trainees, and we encourage them. We've got a bigger proportion of overseas doctors in substantive posts than a lot of our other Trusts around the region. [Supervisor_OMG4_POD1]

Supervisors were allocated to all OMGs, regardless of whether they were in a training post or not (C).

I mean here…even if you're not in a training post you're allocated a supervisor, the trainee's supervisor would have their ePortfolio to get the same number of assessments, written assessments and things as the in-house trainees. They don't have to go through the RCP process and that sort of thing obviously, and I think that does stand them in good stead for when they try and apply for more permanent positions. So I think they are treated in that respect fairly. [Supervisor_OMG8_POD1]

The allocation of a supervisor also impacted upon satisfaction and commitment to the organisation (M). This level of support was important for Continued Professional Development (CPD), which seemed to be important at AH (O):

Her performance issues really from her point of view is I mean she doesn't have a requirement as such to get her exams in the sense that she's not in a training post, but for her own personal development I think it is mandatory for her to get her exams for her to progress further in her career. [Supervisor_OMG11_POD1_INT2]

On occasions where education support was lacking, this negatively impacted levels of understanding (M) and ultimately upon career progression (O):

I don't think she necessarily got the clearest guidance about what she needed and she thought she'd got her F2 competencies from her last job, but when she applied for GP training they said, no, you haven't, so she's in a bit of a limbo, so she's having to redo time. [Supervisor_OMG6_POD1_INT2]

OMGs from comparator hospitals felt that CPD was not a focus in their organisation, reducing Cultural Health Capital and understanding, and increasing stress about future careers (M):

Most of the people are not really caring about that. They're just okay, go, you're working fine, just work and that's all. A lot of them really and I wanted to say that there is no-one in place who can really feel that you want to get better…so weird is that no-one guides you and tells you with your work or go to there or do that. They expect you just to learn yourself…I was frustrated when I arrived here, but most of the day now I am just confused because I think what I should do, because no-one tells me actually [OMG7_NON]

Some OMGs felt that they were assigned a role purely to cover staff shortages, with no consideration of training needs. This would potentially impact upon performance (O):

…they use you like as your level that you have been working for ages here, like even when I was doing my job, you're supposed to be doing it for like three or four years before you start this job, or three years or a couple of years, at least foundation year, but I didn't do that and everyone asks you to do something without consideration that's your first job. [OMG7_NON]

This lack of guidance and support also meant that satisfaction and confidence in the organisation decreased (M):

> *…the working environment in this thing is not very healthy. ...there is a lot of mess and chaos, unfortunately. It's not very organised and they don't know what they're doing unfortunately. And they don't know that they are messing with people's lives actually, or people's careers. [OMG6_NON_INT2]*

> *…if I was able to discuss things more, seeing progress and people tell me how I am progressing or I'm not progressing or whatever, then it's more creating a positive environment, but I cannot achieve that in my current job. [OMG7_NON_INT2]*

OMGs will not remain committed to an organisation if they do not feel they are supported in their career (M); increasing the likelihood that they will leave (O).

The data in this section provides a great deal of evidence that a supportive and open culture is necessary to facilitate both success of the intervention and OMG transition.

7.3.1.5 Context of the work environment

Individual circumstances of the organisation – shortages of staff:

As mentioned previously, some Trusts faced more difficulties than others in supporting OMGs due to resources and workload (C) (see Chapter 6 for detailed exploration of contextual issues in each case study site). Those who worked in BH discussed the stress they felt due to the lack of staff and overall support (M):

> *I see that there is a huge lack of personnel, of staff in the hospitals and they don't care about your problems, about your difficulties. [OMG9_NON]*

The lack of support (C) led to a reduced confidence in both themselves and the Trust (M), and potentially hindered retention (O) (evidenced in retention data):

> *… but it's the feeling, it's like when you are slapped in the face you think that the next second you think that it will happen again. It's like a shock that you are going through…after this experience in the UK I am terrified. I don't know the new positions that I hope to find, how it will be. [OMG9_NON]*

The lack of support led to patient safety issues (O):

> *…it is like a common secret that the newcomers should do the on-call shifts and this is, they could one day they may find themselves in the jail or whatever, because this is very dangerous. You know, it is like going to a new place and that you have to treat lives and you don't know nothing and they tell you, you are responsible for everything. [OMG9_NON]*

Where staff shortages were high at AH, OMGs who faced difficulties in their transition were also less likely to get adequate support (C), therefore enhancing difficulties they already faced (M) and this hindered performance (O):

> *I was on call and they were majorly understaffed, like not the doctors, it was more like nurses, and there was a concern about a patient safety. And it datixed, but the next day happened, something happened again, it had to be datixed again. [OMG8_POD1]*

These difficulties led to increased stress within the whole team (M):

> *…he was appointed at the senior level and he absolutely wasn't at that level. Not because he wasn't a good doctor, just because he wasn't there yet. And I think that pressure within the team is very difficult, because we can't have extra people on to support us because our doctors are from overseas. [Supervisor_OMG13_POD1]*

> *I had a guy a couple of years ago who had no knowledge, absolutely none…I think ideally these guys would be supernumerary for the first six weeks. But we just can't do it…the pressures on the ward are such that actually taking eight or 10 juniors out to give them specific training is really difficult. [Supervisor_OMG4_POD1]*

Size of the organisation:

When OMGs began their first post in a smaller, supportive working environment (C), it created opportunities for Cultural Health Capital (M) and fewer performance issues were likely to arise (O):

> *I started in a small hospital, so everything was supervised very closely. There was no busy environment, nothing like that. So I didn't [have performance issues], thankfully I was well supported and that's why I didn't. [OMG2_NON]*

In comparison, some OMGs working in larger working environments (C) felt unable to ask questions and so did not have the opportunity to increase their Cultural Health Capital (M). One individual highlighted that they felt unable to raise important queries about their practice to seniors, hindering their understanding about best practice (M) and likely resulting in patient safety issues (O):

> *…some departments have 12 consultants, 14 consultants, if it is a massive thing…you don't want to ask. [OMG7_NON_INT2]*

This may explain why incidents, such as misdiagnosis and inappropriate taking of bloods, occurred following POD (see section 7.2.2).

Levels of support offered is dependent on department, grade and post:

Different departments within the hospitals sometimes offered differing levels of support:

> *But what I have noticed that when you start talking, when you start expressing yourself, you are the troublemaker and there is also like backstabbing and for surgery is really very, a hostile field and it's not an easy field…I understand it is more the department…[OMG7_NON_INT2]*

> *Because when I went to A&E, when I was in A&E I think I always hesitate in asking the consultant. I would ask the registrars, and the registrars themselves were a little bit busy, so they get upset about asking them. But then when I moved to orthopaedics I would just work on my own. But then I might have had one or two issues where I should have called the consultant, and I think they were a little bit harsh on that. And so I learned a lesson. [OMG8_NON_INT2]*

As is evident in the above example, expectations and available support were different between the two departments. The individual had learnt not to ask questions in A&E, therefore was not aware what was expected of him in Orthopaedics. Therefore, when managing patients alone (as he felt was most appropriate), issues were raised (O).

Departments which relied more heavily on OMGs offered greater levels of support (C):

> *…they often expect you to be more competent and more vigilant than asking things all the time. But this department has most of the doctors come here for this post are overseas. So this could be the reason that they are more supportive than usually the people are in NHS. [OMG5_NON]*

The initial amount of support offered to OMGs also depended on their grade and post (C):

> *Actually no one gave me training, but when I moved here in this Trust as a Foundation doctor, F1 and F2 training, as a trainer, here it was much more organised. And the whole group knows each other, and I mean five of them are working with me currently, which is good. And most of them, we meet every week, for teaching, and sometimes we meet outside the teaching as well, so, which is good. [OMG3_NON]*

> *I was a locum in my first four months when I got here, so probably no one was interested…I felt like no one actually cared. [OMG7_POD1]*

Location and local community:

The local context and surrounding community of the workplace was also important (C). Many issues were raised by OMGs working in BH, feeling both unsatisfied and isolated (M). The area did not offer OMGs what was needed to make both cultural and general adjustments (O), for example, there being no shop selling halal meat for those who were Muslims and there was limited transportation. UK graduates doing foundation training highlighted how

difficult the area was to live in. Therefore, those coming from overseas looking for longer-term posts were often dissatisfied (M). The ethnic diversity in BH was also very low. Many examples were given of racist remarks made by the patient population there. Because of these factors, retention of OMGs was a problem in BH (O) (illustrated in the retention data). A lack of support intervention intensified this further.

The middle-range theories developed in the realist synthesis suggested that the context of the healthcare organisation would affect OMG transition. The findings here support this.

7.3.1.6 Barriers

Monitoring and recruiting OMGs for the intervention:

One of the major barriers to implementation of POD was the hospitals' inability to monitor when OMGs were starting and leaving their jobs in the Trust (C). The complicated process involved in recruiting and employing OMGs has been mentioned frequently throughout this project. It is a difficult task to identify OMGs working within each Trust, moreover knowing in advance when OMGs were starting their employment was often unachievable. Therefore, recruitment for POD was mostly last minute (C), which increased the stress for OMGs who had to try to manage their time with their supervisors and colleagues (M) (this links to issues with dissemination and workload). It also meant that some OMGs were unable to attend POD (C), meaning they were unable to acquire the same knowledge and understanding as their colleagues who received the intervention (M), and potentially impacting their practice (performance data illustrated OMGs who did not attend POD were involved in a higher percentage, and variety, of incidents) (O).

The Education Department at AH were able to identify OMGs in training posts and, for the most part, knew this information in advance:

> *Well the foundation level…they have to be at the interview. Well sometimes in paediatrics we do offer them the post through the phone, you see. So these are the issues. [Supervisor_OMG6_POD1]*

Complications arose when seeking to identify OMGs taking up stand-alone Trust Doctor posts. No database was in place to monitor this group and it was not always clear what level they were working at. Although employed by the Trust, the Education Department was unable to find out when these doctors were starting until the last minute, or until they had physically begun working. This group was also difficult to support as they tended to move between hospitals (C). These factors likely reduced satisfaction (M) and hindered general adjustment (O):

As a Trust Doctor you don't have the stability, so I have friend who has the same problem. He is a Trust Doctor, each year they are in other city in England, which can be really difficult. [OMG2_NON_INT2]

Other OMGs outside of these posts, such as locums or those taking higher level positions, were also hard to monitor. This is because they were generally employed by external organisations and not on the Trusts training database (not having supervisors). OMGs in these positions were not recruited for the current evaluation as they did not take part in POD, however it did highlight issues that needed further exploration. A single database that showed all employees in the Trust did not exist. These doctors faced similar difficulties to, if not more than, those recruited for this project:

I've come across one or two locums, and I've had to stop them from working because of their language, well they're Europeans, the last doctor who I had to stop working, he couldn't speak English. [Supervisor2_OMG3_POD1]

It was also difficult for the Education Department to identify if an individual graduated overseas. Assumptions were instead made by names, which was not appropriate. Place of graduation is not highlighted to educators as the GMC do not want to label individuals. For this project, GMC numbers were used to determine place of graduation.

Furthermore, it was difficult to capture all OMGs new to AH at one single point in the year (C). The Education Department was able to identify those starting in training posts, therefore POD was implemented at a time that would target the majority. However, OMGs who attended POD still differed in terms of the length of time they had been in the UK or working at AH (see section 7.3.3.2 on individual differences). Assumptions should not be made that OMGs do not need POD because they are not brand new to the Trust and therefore have necessary knowledge and understanding (M):

So the transition is taking place at a good pace, but what I think is one year is too short for you to have a complete transition. Probably another year or one more year probably, I think three years I will be at home here. [OMG12_POD1_INT2]

OMGs do not always get time to adjust before practicing (O). Therefore, there were many discussions around the need to make POD mandatory (C). Only those at Foundation level could have mandatory training enforced, meaning that other OMGs may miss valuable training (M):

…we can't mandate it, not least because we don't employ half of them, they're employed by the LET. The problem is the ones that don't want to go on it may well be the ones that most need it…the ones that fall through that net totally are usually

a total nightmare. And they're very difficult to catch, because you can't mandate the majority of these things. [Supervisor_OMG4_POD1]

Support for Trust Doctors:

Other barriers were highlighted that hindered the amount of support offered to Trust Doctors, including rotations and their role in the organisation (C):

And if they're in Trust Doctor posts then they are often the people who are moved from one ward to another to fill in gaps when it's winter bed pressures and things like that. Because ultimately they're not in a training post, and the trust is employing them and therefore we can do more what we like; we're not going to have the comeback of the medical schools and things and the deanery saying why have you put this person, why do they move wards every month? So you have got issues where they move a lot, and that can cause problems. But that's necessary, do you know what I mean? [Supervisor_OMG6_POD1]

If someone is not doing foundation training and if he is working as a Trust Doctor, he will find it difficult...[OMG3_NON]

Increasing support from supervisors aimed to address these issues:

…a lot of these doctors will be in Trust posts if they don't fit in a box. So I suppose it's supporting that role as well as the overseas doctor role is pretty important, so that people are assessed properly and given feedback and career advice and all the rest of it. [Supervisor2_OMG8_POD1_INT2]

However, the regularity of moving wards and a lack of structure in their work prevented some of the OMGs from getting the contact that they required with their supervisors (C):

I haven't had as much direct supervision working with her as I would want, because she's been moved to other wards to fill gaps. [Supervisor_OMG6_POD1]

Initial stability and ongoing support (C) was needed to aid learning (M) and overall transition (O):

I would say I am more comfortable now and the transition, it's an ongoing process, so I would say that the complete transition has taken place probably 50%, because since I am working in the same area I am very comfortable, but if I go to paediatrics or some other subspecialty I would need, it would take some more time. [OMG12_POD1_INT2]

Barriers to working in the UK:

Barriers caused by practicalities of working in the UK were also an issue for OMGs (C), leading to increased stress and dissatisfaction (M). Visas were mentioned a great deal, which caused distraction and hindered performance for some (O):

Once you get this then there is no problem to start, it can even start clearly to be a matter of the quality of what you're doing rather than the visa which is distracting you. [OMG7_NON_INT2]

Issues around bureaucracy and paperwork were also highlighted as causing stress (M) and hindering the ability of OMGs to work effectively (O):

...my main stress about that, was my GMC licence for the first four weeks of, when I started working, it was like coming down to the wire whether the foundation programme would drop me because I'd missed too many days in training, or I'll have to repeat the entire year or whatever… I really just slid by from that aspect. Everything else was peanuts, you know, it was just that additional huge stress I couldn't focus on work. [OMG4_POD1_INT2]

Where OMGs faced barriers in developing their career (C), they lost confidence in the organisation and became increasingly unsatisfied (M):

So what I'm trying to do is trying to be in the central system but I can't apply, for example, core training as a national one because there is, although there is no visa limitation, but because simply they make like a, you could call it a locking mechanism, so I spend one year doing some job in UK, after 18 months in surgery I cannot work, I cannot apply for training in surgery, that even at the same time you cannot apply unless you have one year GMC registration. So if I need to choose a word that describes it…it's the word inefficiency…makes you not able to produce really, to start doing some area of clinical really. [OMG7_NON_INT2]

…they don't care about your problems, about your difficulties. They care just to fill the gaps, and this is dangerous for you and for the patients. And they put you in a very difficult situation that you shouldn't be. [OMG9_NON]

This lack of satisfaction led to thoughts about leaving and exacerbating retention issues and problems of staffing levels (O):

I'll give it more time, if I couldn't achieve, I need to move on, you know. [OMG7_NON_INT2]

These initial experiences need to be taken into consideration when thinking about the support that should be offered to OMGs upon their arrival to the UK. These challenges further add to the stresses of trying to integrate into the NHS which in itself is a challenging prospect.

The initial theory does not place much emphasis on barriers at the organisational level. The current findings suggest that organisational barriers can play a substantial role in determining the extent to which interventions are successful.

7.3.1.7 Summary of organisational factors

A number of organisational factors were identified in the data, highlighting the need to adequately develop interventions to address OMG needs. A supportive and open culture alongside implementation of the intervention was crucial in facilitating a successful transition; this was evident at AH. Barriers to success included high workload, inability to monitor and recruit OMGs, practicalities involved in implementation, context of the work environment (such as location) and practical issues involved in moving to the UK. Dissemination of information, leadership and available resources facilitated ease of implementation.

7.3.2 Training context

Training level context refers to the training and support offered to OMGs, both during implementation of the intervention itself and ongoing support outside of the intervention (in practice). The realist synthesis highlighted the importance of ongoing support. The training level factors that were found to impact upon intervention success, as well as overall transition, are presented below.

7.3.2.1 Intervention - Design and content

Need for an ongoing support package rather than a single induction session:

Interventions implemented for OMGs differ in terms of their design, those in the UK largely being half day to one day in length (evidenced in Chapter 4). However, as the findings from this evaluation suggest, a longer and flexible induction was important to ensure individual needs were addressed and individual feedback was given (C). This facilitated OMG reflection and learning (M), and ultimately impacted upon CPD and performance (O):

> *Because one it wasn't like a straight five days, so it was a bit staggered. So you'd encounter new problems on the wards, and you can bring them up, or because the programme was obviously quite flexible and they would ask us what we thought was necessary, what we wanted to do, what we were struggling with, and then they kind of went that route and tried to help us. So if it was like one or two days I think it wouldn't have been as helpful because it doesn't give you that time to kind of think about, it was all about reflection wasn't it? [OMG4_POD1]*

As the individual above states, the staggered design was important as it meant that they were able to bring their own experiences from recent practice to the training, which enhanced *transformative learning* (self-awareness, beliefs, behavioural) (M). It also helped lessen the impact of the time they were taking away from practice and would have helped reduce the pressure upon the hospitals.

The length of the induction also meant that relationships were established (C), helping to reduce anxiety by having time away from the clinical setting to discuss issues specifically related to OMGs (M) (see section 7.3.2.7):

> *… having like a few days was really good, because you got to meet those people and kind of not in the clinical setting yet. So like that's why I think that overseas doctors thing being a separate thing…I think it was the right thing, it's good. [OMG4_POD1]*

The refinement of POD, following the realist synthesis, led to the implementation of a support package, rather than a single induction. A buddying scheme was therefore

implemented to provide a figure that OMGs could contact outside of the clinical setting (see section 7.3.2.4).

Content of the intervention needs to address gaps in skills, knowledge and understanding: As discussed at the organisational level, addressing gaps in knowledge and understanding caused OMGs to reflect (M) and apply new understanding to their practice (O) (also supported by questionnaire and performance data):

> *Now I do understand what decisions to be made…now I'm taking history, now I'm doing examinations, more thinking about the patient and not just the diagnosis…[OMG10_POD1]*

> *He got a lot better himself as the year went on. I think he has reflected on a lot of stuff and I think his ability to reflect has improved. [Supervisor_OMG9_POD1]*

Specifically, there were improvements in communication and interactions with both patients and colleagues following POD (O):

> *Mainly the communication I would say so…at least that you know how to improve; even if you had a bad situation or bad communication, bad relationship, how to improve. [OMG11_POD1]*

> *I think with colleagues especially, I don't know if you remember I had, at the very beginning I think that's when I had some minor issues. But I think after that I've never had issues with speaking with people. It was more like the actual professional part. It almost sounds worse but it was more the skills of just relating to a higher grade doctor rather than oh they think I'm rude or they think I'm being dismissive, when I don't want to be. [OMG9_POD1_INT2]*

Supervisors also noted clear improvements (O):

> *…she has become more assertive I think in recent times and she does make her concerns more vocal if you want. She will either write an email or she'll ring and tell me that's she's had an issue with such and such person. [Supervisor2_OMG11_POD1_INT2]*

This improvement was further supported by performance data (section 7.2.2), in which there were no complaints about the communication of OMGs that attended POD. In contrast, some of those who did not attend POD had complaints made about their communication skills.

The focus on specific language issues was beneficial to OMGs (C). The findings support the notion of transformative learning (M) (supported by the questionnaire data):

…part of it is also just like turn of phrases that you don't realise that you're using, and little linguistic ticks that you might pick up or have, I don't know, and it's funny because now I notice them on other people, but obviously you don't notice them on yourself as much right…I even noticed a lot myself that a lot of times when I'm on the phone I'll say 'oh hello hi, listen this and this and this', whatever I'm saying. And the listen bit, I just say listen, but it's not trying to be, you know, listen to me, it's just like saying this is what's up. But now I've noticed it and so I'm trying to sort of, not use it all but just maybe not say it constantly. [OMG9_POD1_INT2]

OMGs also demonstrated increased self-efficacy in practice (M) (supported by questionnaire data). These factors ultimately led to CPD and better performance (O):

…getting a bit more insight and gaining a bit more sort of confidence, and also like a few tools to understand and work around, well, not work around but work with people and sort of work on my problems - that certainly met on the problems I was facing. And I think I got that…in my second rotation it gave me the tools to sort of pick up on other things and improve and sort of work on it. [OMG9_POD1]

I realised on that day, or maybe around that time, was that sometimes you just have to be a bit more assertive. And that assertiveness in a positive way gives you not only a better understanding of yourself but your communication skills improve better. So I think I've practised that…in fact it's given me more respect around the place I work. [OMG5_POD1]

Supervisors also supported this:

…she found the communication course very useful. And you could tell that because personality-wise she really changed. She is a confident person. [Supervisor_OMG13_POD1]

…he was already aware of them through the programme he'd done if that makes sense…I think he's reflected and he's perhaps changed how he interacts professionally. So I think he's had some insight into his, the way he works really. I guess what my thought was or take would be that the programme's really good for getting you through that first few months when you're finding your feet I guess. [Supervisor2_OMG9_POD1_INT2]

The intervention also helped to reduce initial stress and anxieties about a lack of knowledge in comparison to peers (M):

…all the things that I struggled with initially, I don't really think about it anymore. So yeah, and I feel, I don't feel like I'm at any disadvantage compared to other F1 doctors at all anymore. [OMG4_POD1]

Some of those who attended the HEENE intervention raised issues with the content, feeling that it did not fully address their needs (C):

That meeting was more about, you know, don't do that mistake, don't do that, don't do that, so it was all about don't do. But it was never about what we can do. [OMG2_NON]

The importance of being able to relate to others in the same position was highlighted by the majority of OMGs that attended POD (discussed further in peer support; section 7.3.2.4). However, many OMGs felt that support from OMGs who had previously made a transition to the UK would have been helpful within the induction sessions:

Maybe it wouldn't be a bad idea to have people there, to include people who were overseas there, you know what I mean? Because initially for that programme that's what I was looking for, is like knowledge, a mentor, or like advice or like relation that I'm not the only person struggling with this. So just bringing us together with the other people that are overseas actually helps. [OMG4_POD1]

POD2 was refined to include this figure.

This section illustrates the importance of design and content of the intervention in successfully facilitating adjustment; an ongoing support package was more beneficial than a single induction session. This supports the findings from the realist synthesis.

7.3.2.2 Intervention - Learning and the environment

Learning preferences:

The need for experiential learning was highlighted throughout (C). Active participation and reflection led to increased understanding about UK practice and transformative learning (M) (also supported by the questionnaire data), which was perceived to improve practice (O):

…in the scenario you would like me to think about the steps and things a bit more. But it definitely improves you, it prepares you for the real situation, because sometimes you do need to think in a step way. [OMG1_POD1]

The opportunity to observe peers practicing (C) was also viewed as important:

…you can actually sit down and see what they [peers] are doing and notice things that you do the same and see how you can improve on it as well, so yeah, that was good as well. [OMG1_ POD1]

As self-awareness increased, feedback was accepted and transformative learning occurred (M). Thus, following POD they were aware about their needs and the realities of practicing in the UK (as the interview data suggests). It is also possible that since confidence increased following POD training (questionnaire data illustrates this), they felt able to be honest and open about their understanding and capabilities (M).

Despite OMGs viewing the simulation sessions as effective, being more 'real' than role-plays, many stated they felt uncomfortable or anxious during the sessions (M). This was often because they had not been exposed to such learning styles before (C):

> *…you don't know who qualifies where right, and what downfalls they have in learning. Like some medical schools are worse than others, so maybe they have zero experience from a simulation. Where I have quite a good amount, so that wasn't an issue for me. But it's hard to tailor it for everybody. [OMG4_POD1]*

As a result, they did not always engage fully or act like they would 'if treating a real patient' (M) (taken from questionnaire data), which could have hindered learning and transfer into practice (O):

> *I don't know why I just personally don't take, I don't take it seriously, the whole thing. Some people say it takes time, and obviously the research and the whole training thing, if you can do it on a manikin you can do it in real life, that's what they say, and surely if you, and it did go well, it did go well. Like I did what I had to do, but there was no stress, I think I was way too relaxed and this registrar was looking at me, okay, we need to stress her out, and she changed the scenario for me because I was super relaxed and like just kind of having fun basically. [OMG8_POD1]*

It was on this basis that the decision to remove the simulation from POD2 as role-plays were seen as just as valuable by OMGs (also evidenced in questionnaire data):

> *…they did more like a role play which was amazing, especially F2, because like F2s apply for speciality training and they do have interview for it, and they do like role play and every interview they ask role play this, role play that. It was really nice because we had opportunities in like lots of role play. So yeah, it was a different experience really, it was nice. Definitely without it I think, yeah, it would be harder. [OMG8_POD1]*

Coming in at foundation level, the above individual was not used to the amount of role-play expected. Therefore, they valued the role-plays and as a result engaged more in the training (M). The individual was also aware of what would be expected of them in future training posts, and saw the benefit of this learning style (discussed in role identity; section 7.3.3). Simulation also led OMGs to focus on their clinical skills, rather than the purpose of the training; which was communication skills (M):

> *But I think that's [simulation] strictly like a clinical and knowledge based issue, whereas the other things, like the role plays and all that were more based on communication and how to ask questions and how to word things properly and how to deal with those situations. So all the things that I had to deal with or struggled with mainly the communication part. Whereas that simulation was more based on*

how good are you clinically, and I don't think, for me that wasn't an issue. [OMG4_POD1]

Regional programmes did not include experiential learning opportunities and were therefore missing a crucial component in training OMGs in communication skills. These practical experiences evidently support OMG transition (O):

I was hoping that it won't be like the regular other induction that I had had…the generic just like talking. The boring induction which goes on and people drone on…It was more practise, it was very much two-way participation kind of a thing, so it was very good. I found it very good and helpful. I wish I had that when I came and I wouldn't have suffered so much! [OMG2_POD1]

Learning in a safe and supportive environment:

A clear rationale, detailed instructions and expectations were given to OMGs prior to the simulation sessions to try and overcome the latter issues discussed. This also helped those who felt anxious and aimed to increase engagement with learning (M). Although some still faced initial stress and anxieties, they did value the opportunity to practice in a safe environment (C) and saw noticeable improvements in their performance (O):

Yeah, it's quite scary with those sessions, but I'm not so great with them, so the more I practise the better, with those sim emergency situations, so that was really good. I've done it since and I definitely noticed an improvement. [OMG1_ POD1]

I think it's even easier because it's not a real person. I guess you're a bit put on the spot because everyone's watching you, but for me it wasn't as bad because it's not a real person. So if somebody's choking it's kind of an issue, whereas this dummy you're not going to kill anybody. [OMG4_POD1]

The non-threatening and safe environment (C) was essential for engaging OMGs, reassuring them, and fostering their learning (M):

Communication skills in a non-scary environment. If you put too many conditionality to it I'll be scared of it, then it becomes a problem. But softly introduced on a regular basis somehow attached to revalidation will highlight its importance and people will gradually become keen to attend. [OMG6_NON]

This was particularly important since many OMGs attending came from a culture where feedback was often viewed negatively, so feared that if they made mistakes it would hinder their career advancement. It was explicitly stated that this practice was for their own development; to raise awareness and understanding of communication issues, and increase self-efficacy. It was not viewed as an exam, rather a learning experience. This reduced anxieties and stress (M). This also ensured that OMGs were more likely to be receptive of

feedback (C), which facilitated transformative learning (M) (discussed further in section 7.3.3):

> *I did those scenarios with somebody and then somebody who is trained to judge you, in a good way they tell you what are the deficiencies that you… it wasn't like an exam and they were not threatening. [OMG2_POD1]*
>
> *…they tend to perhaps have had less formal training around that. But she has, since then she has gone on to cover up those a bit more easily. [Supervisor_OMG8_POD1]*

Small group discussions in this environment (C) also helped to engage OMGs with the feedback process (M) and facilitated transformative learning (M). Recognising others were in the same position, and learning as a group, was important for those individuals that feared making mistakes. They no longer felt out of place because *'oh you need some help' [OMG3_POD1],* removing stress associated with what could be seen as a difficult situation (M). Discussions also helped to increase self-efficacy and remove self-blame (M).

> *…meeting people who are going through the same thing. I think that was the thing I liked the most, meeting people who are going through the same thing…you could speak with them and realise that they were feeling the way you were. Yeah, it definitely helped with that. [OMG1_POD1]*

Those OMGs that attended the HEENE intervention also discussed the importance of being able to relate to others, which increased self-efficacy and reduced anxieties they faced regarding their practice (M). It also led to increased understanding and transformative learning (M). In the example below, this impacted on wellbeing, performance and the decision to stay in the job (O):

> *He saw I was struggling and maybe he couldn't help me and I'm sure he saw that course and he said well this course is for you. And I really appreciate and I will be always grateful because he changed my way of thinking. It changed my mind; in the moment I was going to go back to [home county] really because I was not feeling comfortable at all…self-confidence is low until they tell you it's common, or you can expect that from an overseas doctor, you feel better because if you know that this is common, if you know that people feel like that when they move to a very different environment, you know, not only the system but the language, things that make you feel unwell, because you start to feel that your performance is not good…now I'm more settled, I know what I have to do, and so I'm feeling more self-confident and of course I'm feeling happier…Your performance is going to improve. [OMG11_NON]*

Findings from the realist synthesis touched upon the importance of utilising appropriate learning techniques to enhance OMG responsiveness and learning, and for the intervention

to take place in a safe environment. More emphasis is given to the importance of these factors in the evaluation findings.

7.3.2.3 Intervention - Individual needs

OMGs will only engage (M) with content deemed necessary and relevant (C). Individual needs were therefore assessed during the training by the tutors and individual feedback was prepared (C). OMGs seemed to respond well to written feedback (C), increasing their engagement with the process (M). Personal Development Plans (PDPs) were also made for each individual with a senior faculty member. As a result, individuals were more aware about what they needed to work on when back in practice (M). Supervisors recognised an improvement in performance (O):

> *I'm sure it has helped. She certainly makes her mark a lot better than she did in the beginning. [Supervisor_OMG11_POD1]*

OMGs reflected on their learning needs in practice and further changed their behaviours accordingly (transformative learning) (M). This was particularly important where OMGs were not used to reflecting on their practice (O) (discussed in previous section; 7.3.2.2):

> *…she is engaging well with that. She has done a few more reflection in her current specialities as well and so it seems like she is improving on that. [Supervisor_OMG1_POD1_INT2]*

Educators suggested that formal feedback from the training would benefit supervision and overall CPD (O). This was supported by supervisors from AH:

> *…it would let them see how they'd improved. [Supervisor_OMG4_POD1]*

As is highlighted at the individual level (section 7.3.3), OMGs are a very diverse group bringing with them a range of experiences, knowledge and circumstances (C):

> *…there's a whole different grading or scale of people, language skills are really different. I remember being at that thing and there were people that had a lot less problems with their skills and a lot more problems with their language. And other people have more of a, it's a cultural gap that they're missing, so that's what they need to fill. [OMG9_POD1_INT2]*

> *And the fact that she is so conscientious in her work and tries to get everything sorted doesn't help. Also the fact that she's possibly not the most efficient person in terms of delegating, rotas take away a lot of time…she is quite religious and then that takes a lot of her spare time. [Supervisor_OMG11_POD1_INT2]*

Questionnaire data revealed that, as a result of differing needs, some individuals did not feel they needed to attend all aspects of POD (C). This was supported during interviews, even though they still found it helpful:

> *I don't struggle with language really right, so I don't know if that affects some of the others who don't speak it very well. [OMG4_POD1]*

> *I think the juniors who sat there, they had more issues, whether they were cultural issues, I could see where they were coming from. [OMG5_POD1]*

A senior member of the group began to disengage towards the end of POD (M), particularly when career guidance was given. Being at a fairly senior level, and having practiced in the UK for a while, it was felt that some sessions were not relevant. This could have led to resistance towards other components of POD:

> *…initially it came as a surprise to be frank, because sometimes you just wonder are your communication skills falling apart here for you to be attending. [OMG5_POD1]*

However, after recognising the benefit, the OMG did engage and transformative learning took place (M):

> *But then yes, after attending it I took it more positively and I wanted to see what I've gained from it. And I would say I still try to pursue courses, even the one I went to yesterday was, the topic was how to communicate effectively in a clinical environment, and there were the SAS doctors, and I think you always learn. There's always room for learning. I think culturally I do understand where it was coming from, because the way we communicate, especially if you haven't been born and brought up here, sometimes you are reminded of it. So I just tried to learn as much as I could from it. [OMG5_POD1]*

Discussions at CH and BH also highlighted the need to 'cherry pick' aspects of the intervention for each individual. They felt that a more rigorous assessment of competencies could take place upon entering the Trust (C), helping to raise awareness of individual needs to both the trainers and OMGs themselves (M):

> *So I mean you could be able to easily identify what sort of problem and what sort of background I had, so what sort of problem I had. [OMG10_NON]*

It was therefore decided that individual needs would be assessed prior to OMGs starting POD2, and OMGs would only attend relevant aspects of the training. It was also suggested by educators external to AH that role-plays could be made more specific to the specialty that the OMG is practicing, helping to highlight any specific concerns.

It was assumed that senior level OMGs would be more self-sustaining than lower grades. However, it is interesting to note that all senior grade OMGs fully engaged (M) with the buddying aspect of the intervention. However, this was largely to overcome social, rather than work-related, issues. Where engagement was low from lower grades (M), this was largely due to the poor timing of implementation (see section 7.3.1.1 on intervention development) (C):

> *I was more into the system and I was like okay, I know how things work there, and I was already F2. [OMG8_POD1]*

> *She's been here ages! I don't think she needed anyone. [Buddy_OMG8_POD1]*

This lack of engagement (M) illustrates the importance of assessing individual needs (C). Not assuming that all OMGs are at the same stage and need the same level of training or support is important to the intervention and the individual:

> *There isn't a single issue you can put your finger on. It's a matter of understanding, and how much have you formulated your support system so that I can have some idea to talk on it, you know? [OMG6_NON]*

A more dynamic approach to individual needs will facilitate overall work adjustment (O):

> *I told him really you need to identify what needs we have…it's much better this doctors from abroad are not going to struggle, and because it's going to be better experience they are going to do their jobs better and then you're going to have, everything is going to flow. [OMG11_NON_INT2]*

In the findings presented in Chapter 4, individual needs are placed within programme design & content. However, the findings from this evaluation suggest more emphasis should be placed on individual needs and illustrates the impact of this on intervention success.

7.3.2.4 Peer support

Importance of a buddying programme – bridging and bonding:

Buddying provided OMGs with an extra level of support that was particularly important for those facing cultural and social difficulties (C). Supervisors noted the important role that a 'buddy' can have, being likely to decrease the amount of time they had to give to their OMG supervisees:

> *I think that having a buddy would have helped her. Probably I had to step in that sort of a role at the time, but yeah, yeah it definitely would have helped her certainly. [Supervisor_OMG7_POD1_INT2]*

OMGs expressed conflicting attitudes towards having a UK-graduate 'buddy' (bridging) or a 'buddy' from a similar (or same) culture as that in which they graduated (bonding). For this reason, AH implemented buddying through an initial 'speed dating' style session (see Chapter 6 for more detail). This ensured that OMGs were paired with a 'buddy' that they felt could offer them the most support. Both were thought to have advantages, very much depending on individual needs and preferences:

> *I was lucky because I had one person who was [overseas graduate], they could empathise and understand where I was coming from, and another one that wasn't [UK graduate], who I mean was also very empathic and stuff, but who knew the system quite well and knew what people, sort of how things were perceived…it can be useful to have a person that is going or has gone through what you've gone, and also a person who hasn't, who knows how what you're doing is perceived. [OMG9_POD1]*

This experience was reinforced by UK 'buddies':

> *I haven't got any experience of what they're going through, so I don't know, you can guess really what their problems are…I don't have hands-on experience of coming into England and working…but I think on the other flipside of things you've got all of the experience of being British and graduating in England and knowing the NHS and knowing the system and what's expected and, the culture change and all the rest of it. So I think there's pros and cons. I think other buddies who have perhaps come across here…have probably really invested another tip, because they've been through it and they know what they suffered with and how they got over and learned from their experiences. [Buddy_OMG14_POD1]*

As discussed above, those from the UK helped OMGs to understand the UK system and culture, increasing Cultural Health Capital and facilitating transformative learning (M). Ultimately, this was likely to improve both performance and acculturation (O):

> *…he sort of told me about some things. Because I didn't think there was a problem before. So what he said sort of opened my eyes and then I started noticing things. [OMG9_POD1]*

Other OMGs specifically stated the benefit of having a 'buddy' from a similar culture (C), also increasing Cultural Health Capital and insight (M):

> *…I have found that some of the UK graduates or those who are here, born and brought up here…they probably do not understand the difficulties another person goes through. So initially I suffered from that also, because I was hesitant in opening my mouth and so I was thought to be dumb! So in that way a person who comes from a similar background…uprooted and came and joined and faced the initial*

difficulties, those would be the better people to have. So someone who was already here and managed it successfully obviously is the better person. [OMG2_POD1]

…the person that was buddied with me was purposely buddied with me because he was Nigerian…so it was really a very perfect match. Because he was able to really ease me into the system. And down from things like where do you get the blood pressure machine on the weekend, to things like where do you get Nigerian food [OMG1_NON]

Regardless of where they graduated, the 'buddy' provided support and information that helped to reduce stress and anxiety and meant more time was given to learning (M):

…definitely a great difference…like what we should be doing and what should we expect…release our stress as well. [OMG9_POD1]

...I think having a good start and having that support there just helped me get on with learning, if that makes sense. [OMG1_NON]

Whilst utilising the experience of other OMGs is important, issues may arise if OMGs become too dependent on other OMGs only (C):

I think that foreigners who've been here for a while are more helpful with foreigners. We tend to support more, that's why I made friends when I was in the overseas doctor course, but I can't have any English friends, I don't know why. But yeah, a foreign 'buddy' allocated to me is nice. [OMG7_POD1]

The individual above was unable to interact with those from the UK the entire time they had been living here, impacting both interaction (e.g. teamwork) and cultural adjustment (e.g. social) (O). Both bonding and bridging social capital (M) must take place to ensure interaction adjustment (O).

Buddying crucial for Trust Doctors:

Most of those doing foundation training already had some support in place. In comparison, Trust Doctors in standalone posts were most likely to need the extra level of support (barriers discussed in section 7.3.1.5; context of the work environment) to increase their knowledge and understanding about the system (M):

… I want to check it out whether there is anything that can help me kind of thing. And the other thing is my assessments and everything, ePortfolio, because I'm a non-training post so I would like to check with her these things. [OMG11_POD1]

…a lot of them don't necessarily want to come and speak to a consultant for half an hour, they'd rather speak to one of their colleagues. So I think a 'buddy' system would be good …a lot of these Trust Doctors or the non-training posts get moved around

from ward to ward to cover gaps, they don't get that continuity, the supervision level with the senior, so the juniors they change all the time. I think it would be helpful if there's just somebody they can go and have a coffee with or have lunch with and feel like they're part of the team, particularly those starting out of synch. [Supervisor_OMG8_POD1]

Organic relationships:

Proximity was important in developing organic, rather than formal, relationship:

We've had one sort of meeting, but no, it's mostly just at work, because we spend eight hours a day five days a week together. So it's just when stuff crops up, you just kind of lend a hand or give some advice, or just listen. [Buddy_OMG8_POD1]

'Buddies' can increase Cultural Health Capital during the initial move to the UK workplace; offering resources and increasing optimism (M):

…So it was like the best case scenario for me I think with her. It would have been a lot more difficult…when I first got here she just invited me for dinner and stuff, so we talked about stuff. I had like an interview here when I showed up, so she ran me through what they might be asking, did like a scenario just to see if I'm presentable, just like an interview. So she helped me with stuff like that. Reassurance, you'll be fine, I did it, this and that, just kind of moral support really. A window, like a lifeline for me. [OMG4_POD1]

Some OMGs did not utilise their 'buddy' fully because they did not feel comfortable approaching them in fear that it would be 'bugging' them. This concern highlights the importance of more organic relations being established at the beginning of OMGs transition allowing them to feel more comfortable in utilising their 'buddy' and making the transition smoother:

If she was busy, or because I had that and she was my friend. We could text each other like we're friends right, so it's not a big issue. But like to a stranger it's a bit different. [OMG4_POD1]

I think by trying to do a different formalised process, you're just going against the grain of people's natural instincts. So I think a successful buddying programme would build and formalise that kind of natural process of people which you'd ordinarily do. [Buddy_OMG8_POD1]

The 'speed dating' style sessions aimed to facilitate organic relationships.

Peer support from UK colleagues in practice – bridging:

As briefly discussed in organisational culture (section 7.3.1.4), support from colleagues in practice, regardless of whether an intervention was in place or not, facilitated the transition

of OMGs into the workplace. Where UK graduates were understanding and appreciative of OMG past experience (C), bridging social capital was more likely to occur (M). This supported interaction adjustment, in which OMGs felt able to raise concerns to their colleagues and reduce the likelihood of patient safety issues (O):

> *People know that I didn't qualify here, so they give me, they don't mind it when I ask them a little bit more questions basically. [OMG4_POD1]*

POD emphasised the importance of talking to local doctors to aid in in their communication skills (O). As a result, some individuals actively sought to learn from graduates from the UK whilst on the wards (M). The individual below place emphasis on their increased self-awareness and changes in behaviour (M), resulting in increased performance (O):

> *…there was this other CT1, this was a British born and bred, he helped me out quite a lot, and would explain things to me and sort of direct me, because I do feel I was quite a bit lost at the beginning. So that's the thing, I didn't understand how much I was lacking in doing the jobs and things. [OMG9_POD1]*

Perceptions of hostility, discrimination, and prejudice from UK colleagues in comparison sites hindered social capital (M) and impacted upon interactions (feeling unable to ask questions if unsure). These feelings of hostility therefore led to stress, anxiety and hindered Cultural Health Capital (M). This impacted both performance and retention (O) (perhaps reflecting the difference in performance and retention data between case sites):

> *I would say it's a bully. She insulted me, she humiliated me…my problem is because of her behaviour my progress is slowed down. Because if she was supportive and that, I would say my recovery is much earlier. [OMG10_NON_INT2]*

> *So it was a lot of burden for me. And many times I helped them [colleagues] to put intravenous cannulas and then they went and told to the consultant that I am not good to the intravenous cannulas and they did not say even thank you…the consultant told me I would expect from you as a registrar to know how to take blood and put intravenous cannulas, but I see that the F1s are, yet I was the one that was helping them. I felt like being in a hostile environment. Nobody would like to help or to support me. It was like I was one and everybody was from the other side. [OMG9_NON]*

The above experience evidently hindered Cultural Health Capital (particularly optimism) and ultimately wellbeing (O):

> *I came with different mood and every time I am going to the hospital I don't feel happy…I am making experiment of myself to see how I will adjust, how I will get used to it. It is my first time that I have this experience… it will be too big stress to try*

again another country. I also did this thing three times to move for luggage by train from one city to the other and also to go to a new country to find new accommodation, new people and a new system and I don't know what. You get afraid that even there they will be like this. [OMG9_NON]

UK born junior colleagues were reported to have a lack of cultural awareness on many occasions:

I think the difficulties often tend to be with junior colleagues. So, you know, her registrar colleagues from what I know, have been, she is related well to them. But certainly with juniors there is sometimes, she's found it hard. [Supervisor2_OMG11_POD1_INT2]

So, I mean, and throughout that one week, one or two, or most of the foundation doctors working there, they were all angry with me because I didn't know how to, because I was asking questions from everyone, even the nursing staff, and they were laughing at me. [OMG3_NON]

This may explain why incidents that were reported against OMGs at AH (see performance data in section 7.2.2), despite being deemed inappropriate.

Some OMGs from the comparative Trusts also highlighted a lack of support from senior UK-born colleagues. Again when asking for help, some faced negative reactions. A lack of cultural awareness is evident in the examples below (C), blaming OMG difficulties on a lack of knowledge. Stress and anxieties were apparent (M):

I asked her to show me and she actually went mad at me and she went to the consultant, on the first day, one of the first two or three hours…he shouted at me come into my office, and who are you, and from where you got your training…? He was saying what the hell have you been doing in this country? Okay, you don't know about these things, but you should have got some training. And I said I'm not aware, they haven't told me, this is my first day. I remember he shouted at me like for five to ten minutes, and I was really scared. I said this is my first day in the NHS, this is my first day in UK practice... [OMG3_NON]

…the British people they were…they were really arrogant and not helpful and they were treating me like I am rubbish, I don't know why. Every time I had to make them a question they were like, they did not like it, so I felt really in a difficult situation. [OMG9_NON]

Despite these OMGs searching for opportunities to increase their understanding and Cultural Health Capital, barriers were created by those unwilling to offer support (M). Negative reactions to asking for help often lowered self-efficacy (M) and meant some OMGs were anxious about asking questions (M), hindering interaction adjustment (O):

So I felt, okay, I'll try a cannula then, I said okay, I'll give one a try. This is really bad, this is really bad, I said I can put a catheter, I can put an NG tube easily, I can put the others easily. That's what I've been doing in last one year, I haven't done cannula thing, because the nursing staff usually does where I worked. Now actually I was trying on the next day and I got through the cannula because it's that big, very big, so and after that I was fine, after one week, one and a half weeks, I was fine. [OMG3_NON]

I'll say that it's been tough. In particular in orthopaedics it was horrendous. Well, basically I didn't get any support from seniors. I felt like every time I wanted to approach them I felt like the last person on earth and I felt so stupid because I had to go ask them for help or an opinion, so that wasn't okay because I was the SHO on call, so basically for any orthopaedic problem I was responsible. [OMG7_POD1_INT2]

This highlights serious patient safety issues and may lead to incidents like the misdiagnosis reported in section 7.2.2 (O).

Peer support in practice – bonding:

OMGs from AH reported that those who had gone through the same transition were able to support them in practice:

I mean there's plenty of people that, well my consultant there was actually Spanish so he knew what it was like. He was there to support me… [OMG9_POD1_INT2]

The same was illustrated by those in other Trusts, which facilitated social and Cultural Health Capital, and increased self-efficacy (M):

…just having all those people around me who understood what I was going through, they helped me, they encouraged me, they gave me examples. They helped interpret things for me. [OMG1_NON]

However, one individual discussed the anxieties he faced due to a lack of support from senior OMGs (M), which had the potential to impact on patient safety (O):

…so people who are coming from Pakistan, India or Bangladesh or even from the Middle East, who spend a long time here, who become accreditation and become consultants…they start knowing you that you are not familiar with the system, you are not feeling secure to handle this, you're feeling a little bit down. Rather than supporting you, they take advantage of me, of the position…make you take over something you shouldn't do. [OMG7_NON_INT2]

However, as mentioned previously, OMGs are more likely to ask other OMGs for advice, particularly if hostility is felt by UK graduates:

I didn't know the way it was practised. What should I do? I asked someone of the Indian consultants there and he helped me out, he told me about SBAR and things, because what happens is unless you are used to that you won't be able to. And I was working in a very busy unit there, so there is very little time to learn all these things when you are also seeing patients. [OMG2_POD1]

OMGs from BH emphasised the importance of having a 'champion'; someone from overseas who had been though the same experience and was understanding of their needs (C). Since support was lacking for Trust Doctors, one OMG took on this role herself to help others in the same position as she had been in. Many stated that they would have left had it not been for her (O). Her support reduced their anxiety and facilitated Cultural Health Capital (M). Those who were in a fairly high positions in their home country benefited from this as they did not feel afraid or embarrassed to discuss issues with her (C). Following this first phase of evaluation, AH appointed an OMG who was fairly senior to take on a similar role, as Trust Doctor tutor (discussed in Chapter 8).

This section illustrates how the buddying scheme implemented at AH intended to enhance the efficiency of the induction training for OMGs. It provided ongoing peer support, which was deemed necessary in the initial theory. Appropriate support from peers, both UK born and those from overseas, was also needed in practice. Negative experiences were likely to hinder performance, interactions and retention.

7.3.2.5 Supervisor support

Variance in supervision needed by OMGs:

Supervisor support (C) was needed to facilitate learning from POD (M) and ensure that the learning was applied to their practice (O). Supervisors at AH were aware of OMG needs at AH. When feedback and support was given in the work environment to overcome difficulties, this aided transformative learning (M), and ultimately improved performance (O):

…my clinical supervisor was there whenever I had any difficulties, like he gave me a big support and he made sure that I am getting adapted to the system quite well. [OMG12_POD1_INT2]

I think over the year he did require quite a lot of direction from me for his ePortfolio stuff but he got an RCP1 outcome…he got a good outcome. But he did need a lot of help from myself. [Supervisor_OMG9_POD1]

As highlighted by the individual above, OMGs may require more supervision at the beginning of their transition:

I think I've invested a lot, probably one of the most amount of times of any trainee in him since he's been here, and since my time as a supervisor, and I think a lot of it was just helping him find his feet and helping him find some direction at the beginning. But I don't know whether you can, how long you can keep using that as a reason for not quite being there or not if that makes sense. [Supervisor2_OMG9_POD1_INT2]

Individual differences, as noted above, will also impact upon the amount of supervision required (see section 7.3.3):

In orthopaedics, honestly my supervisor was like useless really, but I didn't really need him for anything…all I really needed to do from him, for him to sign me off, saying that I'm not a legal liability really…I'm ok with patients. [OMG4_POD1_INT2]

Emphasis is placed on the need for ongoing support:

So it is an issue that won't obviously be solved with an introduction and the five-day or a two-week buddying. [OMG6_NON]

…they will try to catch up on those deficiencies in their own ways at their own speed. And they will eventually get there. But if it is given an orderly shape along with a little bit of a highlight, it will be very positively accepted. [OMG6_NON]

Variance in supervision given to OMGs:

The reluctance to provide higher levels of support to OMGs was more the case for supervisors who were UK graduates:

I don't think other supervisors would be happy to put as much time into her support as I possibly have done…she's just very intense.. [Supervisor_OMG11_POD1_INT2]

I don't think it's deliberate but I think a lack of awareness of the needs of an overseas doctor, so they may have less patience about things than I would have. [Supervisor2_OMG3_POD1]

Assumptions from supervisors about OMGs also led to preconceived ideas about their practice (C):

…at times you kind of think in your head that international doctors or EU doctors may be of a lesser, have less medical knowledge or less professionalism compared to UK ones. [Supervisor2_OMG8_POD1]

I would have thought that all that kind of culture stuff would have worn off now, you know, and I think two years in he should be pretty au fait with the system and the culture. [Supervisor2_OMG9_POD1_INT2]

Those supervisors who were OMGs themselves tended to recognise the need to, and were willing to, offer above and beyond the required support (C):

…she was with me, and I could understand what she was going through, because I wasn't English, I got it myself. So I know what it is like coming into a new system. When she was leaving me she told me that she was very envious of the new person that is coming, that she wished she had started with me first. That's what she told me. [Supervisor2_OMG8_POD1]

This group of supervisors could highlight differences and share their own experiences, facilitating transformative learning and increasing Cultural Health Capital (M):

I did discuss, with her, her background, and where she'd graduated from and what her future is and how, you know, what sort of family she has here etc. in the first two or three days that I met her on the ward. [Supervisor_OMG11_POD1_INT2]

That was basically like a whole communication training for four straight months, honestly it's - so I think that did end up helping a lot. So we would talk about how to get my PDP better, how to get my portfolio logged and all this kind of stuff. [OMG4_POD1_INT2]

It is important to note that the majority of the supervisors who were interviewed from AH were from overseas themselves (see Table 10). This not only represented the high level of OMGs in the hospital, but may explain why high support was perceived by OMGs there. They were culturally aware and invested more time in supervision:

I don't think it's deliberate but I think a lack of awareness of the needs of an overseas doctor, they may have less patience about things than I would have. [Supervisor_OMG3_POD1]

They were also more supportive of OMGs outside of the workplace. This had an overall positive impact on work and general adjustment (O).

Yeah, she relied mostly on me... She had to rent a house outside, get some furniture. She prepared and said some issues there. So those sort of things. I as an educational supervisor was acting more on the social side of things rather than actually from the education side of things. [Supervisor_OMG7_POD1_INT2]

The majority of supervisors at AH consciously provided a platform for transformative learning (M) and ultimately CPD (O), not only for those in training posts, but for those in standalone posts (C):

I think part of her progress that I would like to see is to her to get her exams, and she has been struggling a little bit with that…she doesn't have a requirement as such to get her exams in the sense that she's not in a training post, but for her own personal development I think it is mandatory for her to get her exams for her to progress further in her career. [Supervisor2_OMG11_POD1_INT2]

The quality of supervision differed drastically between Trusts. In comparator Trusts, it was a particular concern for those in non-training posts:

> *So, after four months, someone told me oh I'm your clinical supervisor, do you know that? I'm not sure what clinical supervisor means. So I wasn't aware of that, what the clinical supervisor actually does. [OMG3_NON]*

Unlike AH, many OMGs did not have a great deal of supervision or were unaware of who their supervisors were (C). Many felt anxious and unable to raise concerns (M):

> *After two weeks I went to my consultant to explain him these difficulties, I faced accusations that I am too slow at my work and I explained him, how could I be faster since I have to face all of these problems, and he told me, the problem is that you are not willing to make questions and you are working alone and we are working here as a team and you are not cooperating, and this was not true. [OMG9_NON]*

> *…they can harm you even, unintentionally, but that's what happens, in the end it makes you more frustrated. [OMG7_NON]*

In some circumstances, negative experiences represented more than a lack of cultural awareness:

> *I was struggling about some of the systems and stuff like that...he was threatening…it's not made me feel comfortable that we are here to work together and it's like he must agree a position and you should follow and he has mentioned that don't confront and don't, being some words that, what are you talking about now…just don't make trouble…he is one of the reasons that really it's not brilliant. [OMG7_NON_INT2]*

When the individual was seeking help, he received a negative response, hindering Cultural Health Capital (M). Even when mistakes were made and he was seeking to learn from them, no feedback was given (M). As a result, transformative learning could not take place (M) and more patient safety issues were likely to arise (O):

> *…some incidents happening regarding patient safety and stuff, I wanted to report it and I wanted to discuss it…but there were some real issues and I couldn't discuss it. We should think about how was it the best for the patients what's going on, rather than become sensitive about mistakes…we are not able really to be openly speaking about that…as far as we could now, we try to encourage people to speak, and encourage people to discuss problems, so we are able to improve the working environment, but I can't see this in real life...he'll say, it's just a nursing affair, you went to the patient, the patient is fine. [OMG7_NON_INT2]*

Lack of feedback following an incident was also noted by the individual below (C), again in a non-training post. This led to increased stress (M), particularly as the OMG felt he had been

unfairly treated and victimised. This would not only impact on performance, but retention could be affected by such experiences (O):

> *My supervisor was, clinical supervisor should be reporting to the education supervisor and discuss things with me. But I find a report of like five pages against me to the programme director…So literally at that point really I was very very stressed. He didn't come back and speak to me. He collected some reports…you can say anything really, make accusations…if I'm not able to do this I wouldn't be in this job…if I don't know it who's responsible to teach me? Consultant! …So the best thing that it's very important to know what kind of support you have. Because I was thinking OK, maybe I was confused, you want me to be sacked, you want me to leave this job…. [OMG6_NON_INT2]*

The individual sought help from another source himself and is still working, illustrating the role of individual differences in coping with such experiences (see section 7.3.3). POD specifically aimed to address the issue of individual differences, raising awareness and self-efficacy of OMGs so that they felt able to raise concerns (M) and ensure patient safety and performance (O).

Identifying and meeting needs:

The majority of OMGs in training posts at AH felt able to raise concerns to their supervisors (C), reducing anxieties (M) that may have hindered performance and patient safety (O):

> *I had amazing clinical supervisor, I just raised the concern to him. And it was just out of the corridor and we were just sitting, you know, like lunch break, and I said you know, I'm a bit concerned about this. And he took it quite seriously. [OMG8_POD1]*

Where supervisors at AH did not have as much regular contact with their supervisees, POD helped to highlight OMG needs. However, supervisors recognised a lack of contact as a barrier in supervision:

> *…are we going to say the supervision system's good enough, I don't think it is. I mean I haven't seen him for weeks…that's fragmented because we don't have teams anymore really in the same way, and I think that's a barrier. Because what these people need is consistent support from sympathetic people. [Supervisor_OMG4_POD1]*

The interview data further highlighted that supervisor and supervisee perceptions of the OMGs needs and performance did differ at times. Supervisors were generally aware of any issues their supervisees were facing, for example a lack of social interaction, struggles with accommodation or needs for further training. However, some supervisors stated there were no issues, whilst their supervisee was facing difficulties. OMGs on occasions felt they had

relatively few performance issues, whilst their supervisors stated otherwise. For the most part, if there were performance issues, supervisors were alerted about these (C) and arrangements made for a review of the incident and opportunities for reflection (M).

The critical role that supervisors play in providing ongoing support to OMGs, as illustrated in the initial programme theory (see Chapter 4), is supported in these findings.

7.3.2.6 Training support

A reoccurring message seems to be that OMGs who started in training posts received more support, both initially and ongoing (C). Performance was reported to have improved by all foundation doctors (O), largely due to the reinforcement of knowledge and understanding in practice (M):

> *I feel that I can do a lot more now, and I can manage patients a lot better. I think what's good about it is that everything gets reinforced constantly on the foundation level. So everything sort of gets not taught again but like reinforced, and I can see that it's not only about, also other people don't have necessarily the same set of skills. [OMG9_POD1_INT2]*

Some OMGs felt that they would have benefitted from starting at a lower grade that provided this necessary training:

> *I think if I had to go back into that time, and since it was like I worked like a F1 initially/SHO, I would advise anyone in my position to go through the regular foundation programme, because it helps you so much. I think that training in itself, having a mentor above you, having a clinical supervisor, I had them at all levels. [OMG5_POD1]*

Feeding concerns back to the OMG supported transformative learning (M) and ultimately performance (O):

> *One of my colleagues, originally from Cameroon but trained in Europe, he took me aside and said look, there's something that I've noticed that you need to know about, because I've heard other people talking and this is going on... [OMG9_POD1]*

Support at an early stage was necessary to prevent escalation (O):

> *So I was trying to be truthful and I just started this conversation in front of the patient, which was very uncomfortable for that patient and relative, but I wasn't aware of these things. [OMG3_NON]*

> *I mean SUIs were sort of prevented by what happened with this night shift doctor by being very much trying to be on top of him and really overseeing him. [Supervisor_OMG13_POD1]*

This will make it clear when serious performance issues need to be flagged:

> *I sometimes think that we are, you need to be supportive but sometimes I think we make concessions for longer than we should when somebody clearly is not responding to interventions. It takes a long time to say no enough is enough. So I think we probably are not supporting enough early on, but then carry on carrying on for longer than is probably sensible. [Supervisor_OMG6_POD1]*

Support in practice had to be ongoing to ensure a successful transition took place (O):

> *This hospital, people are unbelievable. I don't think I would get such a support anywhere else. This transition, it's a big change so it needs longer time…I think now I am more comfortable and it's getting…I think other team members have helped me a lot…I am trying to apply what I have learned. [OMG12_POD1_INT2]*

One individual from AH discussed their experience in another Trust prior to starting at AH. She felt that she was not given the necessary support (C) to aid transformative learning (M) and therefore was unable to perform as well as she could (O). This also impacted others around her:

> *…but I kept feeling miserable about myself, so that could have been stopped. If I could have performed better, I would have been of more use, and less feathers would have been ruffled I would feel and I would be not as distressful to have probably, because even when I was not really performing from their standards according to them, I was causing distress to other people as well as me, isn't it? [OMG2_POD1]*

This also led to greater feelings of stress (M) and resulted in them leaving the Trust (O):

> *I think sometimes people don't necessarily get all the support they need, and just choose to leave. [Supervisor_OMG8_POD1]*

Ultimately, given the right support, OMGs will likely adjust to the system (O):

> *…when I've compared her to someone I've had after her who was from the UK, you couldn't even put them beside each other, she really excelled compared to the other doctors I've had. So it just makes you say that if people have the right support and are able to adjust they can do very well in the system. [Supervisor2_OMG8_POD1}*

> *…people let you do something which is not right sometimes and there are even other ways to do it easier or faster or better for the patient, but they don't tell you, they just let you go. It's a major issue and I think again if I want to summarise the system, the whole thing to sum up, you are not getting the best out of me, I am not getting the best out of the system…maybe myself I need to deal with my communication skills, but come on, I need a little help here. [OMG7_NON_INT2]*

Following on from peer and supervisor support, opportunities to perform learnt skills from the intervention, with feedback (C), was needed to reinforce learning (M). All team members needed to be involved in this if OMGs were to perform most efficiently (O). The findings presented in this section are in line with the initial theory.

7.3.2.7 Support and social network

Social networks developed through the intervention

Those who attended POD at AH emphasised the importance of being able to meet other OMGs and develop a support network (C), facilitating their Cultural Health Capital (M):

> *So like in this five day course we all met and we knew each other, otherwise we never knew each other. So it's like that, we can get help from each other, because it's a new place…so a lot of social things help. Now I'm more comfortable and happier, because I have got a few people, like a few colleagues who helps me out and we meet, socialise, that's easier now. [OMG6_POD1]*

The development of a social network not only created a feeling of acceptance and belonging (M), but also reduced stress (M):

> *So the additional daunting thing moving to a new country doesn't exist anymore for me. Which is the nice part, because honestly my stress has decreased from like my limit up like 100% to like you know, manageable, like 50%. [OMG4_POD1]*

One OMG from AH who had been living in the UK for a while emphasised the need for support networks (C) through early implementation of POD in order to reduce stress (M) and aid adjustment (O):

> *I'm trying to deal with it [transition] myself most of the time myself, I don't think we have got enough honestly and frankly speaking. We need to get these kind of programmes and this kind of support group; especially for the doctors come into first, like a year or so. I'm sure they will really appreciate the kind of support group like that. I've overcome a lot of the stress already. [OMG11_POD1]*

Some of those who attended POD still struggled with socialising outside of work, highlighting a need for more social aspects of the intervention (C):

> *I think more social gatherings I think that anyone can attend to. Because I think there were a few parties in the North East, the induction parties but I couldn't be there because I was working. [OMG7_POD1]*

Supervisors highlighted a lack of social interaction as an issue for OMGs (C), impacting on their satisfaction with living and working in the UK (M). This hindered both work and general adjustment (O):

> *Some of them are completely isolated, and we had one lady from Pakistan and she struggled. She was good actually, from the clinical point of view, and she passed her exam part one as well, but she went into severe depression because she didn't know anybody. [Supervisor_OMG6_POD1]*

POD could not cover all needs highlighted by OMGs, however many 'safety nets' were put in place. As well as buddying, a peer support group was implemented to try and facilitate social interaction both inside and outside of work. This group was also requested by the OMGs that attended POD, who wished for a more structured and regular support network. However, due to the barriers recognised at the organisational level (such as workload), very few OMGs attended. Also, as the data highlights, the majority of OMGs were already receiving a great deal of support at AH.

Barriers to developing social networks:

In some cases, family circumstances hindered social interactions (C):

> *I think very good interaction with the team members in the unit and I have generally good support, but outside that my family was there with me until last month, so we have not mixed so much around…I think from now on also I will be looking forward to have more friends now that I am alone here. [OMG12_POD1_INT2]*

Many of those from outside of the intervention group could not develop social networks, despite seeking them (C). This lack of interaction impacted on levels of stress and satisfaction (M) and could potentially impact wellbeing (O):

> *You need to adapt to the UK lifestyle, otherwise you will be isolated and you will be asking for more trouble…you need to make progress in your social and family life and everything. Even if you do your job back at the hospital…you are not speaking with someone else, so no one will, no one there to go out. So you still will be stressed out. [OMG10_NON_INT2]*

This highlights the importance of interventions being implemented at a local level, so support networks can be established (C). Regional programmes, such as the one implemented by the GMC and HEENE, was unable to establish strong networks as attendees were from a variety of different Trusts. Local implementation may have also increased self-efficacy and a sense of belonging, especially where anxieties in socialising were felt by OMGs (M). Difficulties in language caused some OMGs to avoid interactions with UK graduates (O):

I haven't a clue, if I were having a chat with a local person out of the hospital there is a good chance I won't pick up on 50% of their comments or their jokes, why we socially do not spend time outside our houses when we are non-natives, so our only exposure to England is the hospital. Keep that in mind. [OMG6_NON]

However, as previously noted, a lack of interaction with local colleagues may hinder access to resources that would aid in transformative learning (M). As a result, work, interaction and cultural adjustment may be hindered (O).

The importance of group support within the workplace has been highlighted previously. This section takes this concept further and highlights the importance of a local level intervention in creating a strong support network both inside and outside of work.

7.3.2.8 Sense of feeling welcomed

Whether the sense of feeling welcomed was created through the implementation of an intervention or acknowledgement from other colleagues, these initial experiences were important to OMGs (C), who were likely to have given up a lot to move to the UK to practice:

So I paid, I spent so much, but still I am working as a doctor here, okay, for to come in here only, so I have spent that much money, but still you feel you are not welcome here, you are not a person that they are expecting like, so it's - that was one of the main worry for me. [OMG10_NON]

Many OMGs from the comparator Trusts experienced initial dissatisfaction and did not feel accepted (M). A great deal of stress and anxiety was created from these negative experiences (M):

I think I'm friendly and I like to meet the new people, but this that I faced here, it was frustrating, stressful, it was, so far it was a traumatic experience and it was the first time that I had this experience in a new job. [OMG9_NON]

I mean I was just telling you, you won't forget the first horrible day ever in your life. And I won't forget…after the first two hours, I was so scared, I was nearly having tremors. My whole body was shaking. I thought where the hell I am, I'm like an alien here! [OMG3_NON]

The reference to feeling from 'space' was mentioned a lot:

In Greece every time I was going to a new position one doctor introduced me to the other…They didn't introduce me to nobody. I was just like a UFO coming from space. [OMG9_NON]

This led to further stress, anxieties and dissatisfaction (M). The above individual moved to America to work due to a lack of both work and general adjustment (O). In fact, when

conducting follow up interviews, the majority of OMGs from comparator Trusts had left the hospital that they were working in. They had either moved somewhere else in the UK or returned home (O) (evident in the retention data in section 7.2.3). Many also reported wanting to leave:

> *…one more week, a similar experience like that as I had experienced on the first day, I would have left the job. [OMG3_NON]*

In contrast, all of those from AH noted the feeling of being welcomed after attending POD (C). This initial openness helped to reduce anxieties in what would have been a stressful situation (M):

> *So any gaps that I had or kind of like hesitancies or fears or whatever, you know, it was just very encouraging. [OMG4_POD1_INT2]*

Regardless of whether a specific intervention was attended, a general sense of welcoming was created by AH (culture discussed at the organisational level):

> *I think everyone's quite tolerant and helpful and, you know, willing to take a bit of their time to get them caught up to speed. From my experience everybody at [Amity] has been very welcoming to overseas doctors and helpful and, you know, wanting to integrate them just as much as we can. [Buddy_OMG14_POD1]*

Implementers and regulating bodies have stated that they feared creating a sense of stigma by implementing interventions specific to those from overseas, but this was evidently not the case at AH. Both the intervention and culture at AH created a welcoming environment and caused the OMGs to feel accepted (M), increasing their satisfaction (M) and therefore retention (O).

The regional intervention was also appreciated by OMGs, as it made them feel more confident, accepted and welcomed as an overseas doctor (M):

> *I think that is the most important thing I had during that session. I had the confidence that someone is watching behind you. Someone is ready to help you - that assurance, that guarantee's there. And the other thing is, it gives us confidence that they really care about the foreign doctors. Because once I came here I feel like a refugee doctor. [OMG10_NON]*

One individual acknowledged that even though she felt welcomed within her Trust, the problem was the lack of support in practice mentioned earlier:

> *I feel it's a pity for me to leave this place because it was my first place, I have friends, I feel I have friends, I have very good colleagues and at the end of the day they have*

done everything to make me feel comfortable here. Although it is nothing to do with that when you come there is no plan or anything like that, it's not their fault, there is really no plan, it's just that. But it doesn't mean there are not good with you, they are great but they don't know how to support you. [OMG11_NON_INT2]

Her leaving the Trust was due to family circumstances. However, it does highlight the need to take all contextual factors into consideration when supporting the transition of OMGs.

Although referred to in Chapter 4, the need for OMGs to feel welcomed into the organisation was not a key contextual factor. These evaluation findings place emphasis on the role of an initial 'welcoming' in supporting OMG transition, particularly retention.

7.3.2.9 Summary of training factors

An ongoing support package that addressed individual needs, utilising appropriate learning techniques in a safe environment, successfully facilitated OMG transition at AH. Ongoing peer support, both through the intervention and in practice, was crucial. Supervisor support was also a key factor outside of the intervention. Local level implementation of the intervention facilitated the development of a strong support network and ensured OMG felt accepted. The absence of these training factors led to negative experiences that hindered adjustment. The findings suggest that the identified contextual factors outside of the intervention itself need to be addressed if interventions are to be successful in supporting adjustment in all areas.

7.3.3 Individual context

Individual level factors can either hinder or facilitate the efforts exerted at the training level. These factors cannot be controlled at the organisational or training level, however there is potential to address them through interventions. The individual factors that were found to impact upon both intervention success and overall transition are presented below.

7.3.3.1 Perceived barriers

Perceived stigma from being labelled overseas:

Whilst the findings suggest that OMGs were receptive of the specific support offered to them, some did feel that they were 'labelled' as a group. This was particularly evident from OMGs in comparator Trusts. One individual from BH took offense at the label 'overseas', feeling that blame for their poor transition should be placed on the hospital. Particular emphasis was placed on the organisational factors discussed previously, such as shortages of staff. Some OMGs working in BH did not want attention drawn to where they graduated or for it to be seen as an individual downfall. Being viewed as 'overseas' was almost seen as a barrier to this small group that had faced negative experiences (C). One individual from AH supported this, illustrating how the consultant made them feel inadequate (M) because they were from overseas:

> *…she looked at me like you look at a retarded person, you know that look, with a little bit of pity in your eyes and she said, do you understand what I'm saying? Just because I'm not from this country doesn't mean I have a low IQ. [OMG7_POD1_INT2]*

It was felt that organisational factors should be blamed for creating stigma:

> *I think the stigma would come much more from, if you chuck people on the wards they'll obviously make a mistake if they don't know how things work. And then that's when the stigma I think comes up, because then they say oh this Nigerian doctor was f***ing everything up, and that Greek doctor as well. Um it must be that all overseas doctors are pretty bad. And the thing is unfortunately it only takes one person. [OMG9_POD1_INT2]*

Whatever the reason, where inadequacy is felt or stigma perceived (M), this impacted upon interaction and work adjustment (O):

> *…for a doctor who has entered the UK, the first and the foremost thing is not to be noted to be deficient in any way. So if you ask a thousand doctors, how is their English, are they able to communicate, have they found any problem, majority, if not all, will say no I am totally fine. I scored an eight in my IELTS. They will not accept it at all. [OMG6_NON]*

The way in which the interventions were implemented (see training level) was also important in ensuring anxiety and self-esteem were not affected (M):

> *Remember if it isn't soft and sweet it will be - what is the word for it - it will not be perceived a very nice thing and it will just create antagonism for no reason. [OMG6_NON]*

Barriers are already in place for OMGs working in the UK (C) (see organisational level), sometimes creating negative experiences (C):

> *…they treat me like a refugee…there are so much things too you need to deal with. [OMG10_NON]*

Negative experiences clearly added to initial stress experienced by the OMG, as well as reduced their self-esteem (M), and was likely impact on adjustment (O). OMGs therefore need to see interventions as being an effort to help and support them, not adding to their anxiety and stress (M):

> *…people are starting to see it in a much more positive light, and they're telling their pals oh you should go on this, it's really good. [Supervisor_OMG4_POD1]*

> *It would be highly desirable, but if you made it mandatory it might just be another block to these poor folks who are already kind of struggling to get places aren't they sometimes. [Supervisor_OMG6_POD1]*

Some OMGs also reported concern about the stigma created by patients (C) and anxiety that this caused (M):

> *…some people, the moment they saw us, it's when they are not liking this person. [OMG10_NON_INT2]*

> I was really worried…whether I can be able to communicate with the patients properly, whether they see me as overseas doctors like - because I've got a different personality. So sometimes I feel like a bit odd. [OMG11_POD1]

Perceived barriers to living in the UK:

General factors outside of work (C), such as setting up bank accounts, home sickness and the local community, were discussed and added to stress levels (M). This impacted upon both general and work adjustment (O):

> *…it's simple things, like finding where to do your grocery shopping, finding where to do this. So all that stuff on top of working in the medical field for the first time under a different system, it was all compounding on top of each other. So all that made it*

difficult really…it was just that additional huge stress I couldn't focus on work. [OMG4_POD1]

Yeah, family back home, and the other thing is really I miss my foods…they said so to maintain your physiology you need to have your foods, and it makes it a little bit, actually it makes it a problem for me. Still I am struggling with my foods, because I lost my weight. [OMG10_NON]

Regardless of the amount of support offered, each individual will face different transition experiences (O):

Yes, I have a British passport, so that's different from some of my colleagues. I never had a problem with visas and stuff like that. So that makes things easier of course for me. For me I'm glad for that. [OMG2_NON]

Perceived barriers to career progression:

Those coming into training posts may perceive less barriers, particularly around career progression. It was felt that those who were not in training posts faced more stress and anxiety about the work that they were doing (M), and perceived a lack of opportunity for career progression; hindering retention (O) (supported by retention and career progression data):

…they're not being trained so it's frustrating…they can't start moving forward. It's like satisfaction and knowing that you're progressing on paper not just within your own experience. [OMG4_POD1_INT2]

…you don't have right to compete with any, even if you are like excellent surgeon, that means nothing. [OMG7_NON_INT2]

In support of the initial theory presented in Chapter 4, this section illustrates how perceived barriers can impact on an individual and their transition. Perceived barriers both inside and outside of the work context were discussed.

7.3.3.2 Individual differences

Personality and culture – resilience:

The personality of OMGs (C), rather than just culture, is an important factor to consider in overall transition (O). Many supervisors picked up on the role of personality in managing the workload and stress (M):

When he was in A&E he didn't quite get through all of the stuff that perhaps his colleagues are doing. I think the volume at work he finds difficult. I think it probably is more a personal facet of him rather than culture…so he's required a lot of help. I think that might be him rather than culture. [Supervisor2_OMG9_POD1_INT2]

OMGs themselves noted the impact of their personality on their adjustment, particularly their anxiety (M) and interacting with colleagues (O):

> *I was very shy...you're not very confident when you're working with other colleagues. [OMG3_NON]*

One individual noted that due to their cultural background, they were unable to manage stressful situations (O). They quite clearly lacked insight into bullying and how to deal with it (M):

> *Our culture in Asia, personality, is like we try and withhold and be patient as much as possible. I did not break into the air. At that time I don't know what this bullying is, I don't know what harassment is…I try to accept it and hold it, that's the way it is, that's why I was treated unequally…I know that it's not nice, because I've seen other people reacting back appropriately, but for me I don't tell them back. [OMG11_POD1]*

The impact of personality and culture on the transition of the above OMG was highlighted by both supervisors:

> *She struggled a little bit with the responsibility and the sometimes necessary or assertiveness that she had to portray in order to make herself heard and listened to. Because she is, comes from South East Asia, she's not tall in stature and she speaks with a lower voice normally, so a lot of people would easily overlook or overhear. So that I think was a huge and steep learning curve for her. [Supervisor_OMG11_POD1]*
>
> *… I think part of it is probably her own personality and her ability to manage stress. [Supervisor2_OMG11_POD1_INT2]*

Although POD, particularly through ongoing support, aimed to promote Cultural Health Capital (which includes resilience), an individual's personality (C) very much determined how OMGs coped with their overall transition. Resilience (M) was particularly evident in the individuals below. Despite facing negative experiences, they still wanted to remain in practice there (O):

> *I'm a little bit stronger person, yeah, I'm not easily withdrawing. I know there are some chances in life to make things work for me, but no, I'm planning to stay actually. [OMG7_NON_INT2]*
>
> *That's sometimes how we can learn, what doesn't kill you makes you stronger. So you are an inspiration, it gets better, more confidence in handling this situation later on. It's better to prevent it but it can still happen…I'm early in my career. I'm planning to stay, I'm planning to continue. [OMG6_NON_INT2]*

Inabilities to cope with stress (M) also impacted on OMGs social interactions outside of work (O).

> *I would like to improve my self-confidence. All the stress from work I tend to isolate myself and I come from work, I don't want to see anybody, I don't want to talk to anybody, I just want to be with myself and just gather my thoughts and relax. [OMG7_POD1_INT2]*

> *She could not mix with people - I think she was a bit more reserved and was more of an introvert than others. She was frightened to go out on Friday night outs. I don't think she was used to that. Or she didn't want to do it. [Supervisor_OMG7_POD1_INT2]*

Social interaction and support was a key aspect of POD, seeking to reduce stress and anxieties of work, whilst also trying to create relations outside of work. However as is evident from all of the above, some individuals struggled with this, therefore hindering full adjustment (O).

Personality and culture - lack of insight, resistance and motivation:

A lack of insight was something that POD aimed to improve. Opportunity to practice, along with supervisor support, ensured that necessary skills were developed (see training level in section 7.3.2). Having insight into their own abilities (M), particularly in Trusts where support was lacking, was crucial to ensure patient safety (O):

> *You are in risk to have bad outcomes of course. So that's why I was honest with myself and with people here and I told them I'm not going to do night shifts because I don't feel, I'm not confident. Although I have 15 years and I've been doing on-calls all my life I don't feel that I can do on-calls, so you have to be very kind of how do you say self-conscious? [OMG11_NON_INT2]*

Despite the level of support offered during POD, some OMGs that attended still felt uneasy about seeking help (M):

> *I am at an age where I am mostly self-sufficient even in my emotional, this thing, and I won't really lean on somebody else. Those small things like, how do you go about this, or if I were to go here which is the best way. [OMG2_POD1]*

> *I'm not really one to run for help right away, because I feel like oh I know this. I mean if other people are doing it then why can't I? [OMG4_POD1]*

Supervisors also noted resistance to support (M):

> *I suspect it's then people's attitudes that really that's not what they need. They've worked in medicine long enough and they speak English well and they don't need to*

be told how to communicate and they've been a doctor for long enough. Those, I think it's more those sort of personality barriers and attitudes and things. [Supervisor_OMG13_POD1]

This motivation to learn (M) was important for CPD and overall performance (O):

I didn't have any complaints against me. I was all the time very open, trying to tell them if you see I don't understand you please let me know, if you see I'm doing anything wrong please let me know - I was very open in that way. So I think people get to know me and they know that I'm very open and very approachable, and I need their opinion to grow. [OMG11_NON]

Others struggled with this, not being open and engaging with opportunities to learn (M):

…possibly personality-wise initially when she came she appeared quiet, not necessarily very confident, but also didn't really ask a lot for help, she didn't ask many questions. I think she just wanted to learn by watching, by observing. I felt that she struggled but she didn't really sort of own up. [Supervisor_OMG13_POD1]

If someone is not keen to just keep on trying things and after this and after that and do this and go there. They might be lost easily and struggling unnecessarily for a long time. [OMG7_NON]

However, it is important to consider the interaction between the individual and training level. Although an individual may be motivated to learn (M), this may be hindered by a lack of support. The individual below demonstrated this:

Why do you need this? [communication training] You are a surgeon, you shouldn't need it. Well okay, let's discuss it. Young man, no need for this and that's it. (OMG7_NON_INT2)

During POD, one individual was resistant to feedback from the trainer concerning how they greeted patients. It became apparent that this was due to their religion. As a female Muslim, she felt strongly that she could not change her views about the way in which she greeted male patients. One of her colleagues reflected on this. They noted the role of personality (C) in the acceptance of different cultures, being a Muslim herself, both inside and outside of practice (M) and the impact this had on overall adjustment (O):

I think when we change countries, homes, places, it is our duty to try to adjust ourselves to the best. We did not struggle at all because as I said the background we come from, fine. We don't go to pubs, but again when we do go with friends to the pubs we are quite happy to have orange juice and just, it's more like mixing around. So that was never a problem to me. But the problems which I find other people facing it is it is more from the religious angle. Because if they've chosen to come here and

especially if you're working in the medical profession, then you just have to work it out. You just can't have, either just see males or just see females. [OMG5_POD1]

Individual circumstances – support:

Despite facing similar transitional issues, OMGs experiences and ability to cope (M) was very much dependent on their circumstances outside of work (C).

Some OMGs came to the UK alone (C):

And the fact that you're here alone, starting by yourself without any further support from anybody else…So it's almost like which one's more stressful, the fact that you're in a new job, because any new job is obviously tough. Or is it the fact that I'm living in a new country, I don't have any friends, don't have any social escapes, to like get away from it all, no one to lean on, and no knowledge of any like where to go for the simplest things. [OMG4_POD1]

As the individual above states, they needed someone to lean on to help manage initial stress (M). Peer support at the training level helped to overcome these issues (section 7.3.2.4).

Some OMGs had support from their families living the UK (C):

…because I had my husband who lived in UK…so for him to do everything here was quite easy because he was used to the system. If I was on my own, it would be very difficult for me to set up anything, starting from, I remember we had difficulties for even renting a place out. If I just came on my own without any support, I think it would be impossible for me to do that to be honest. [OMG8_POD1]

As a result, less stress was felt by these OMGs (M), facilitating both cultural and general adjustment (O). Support was sometimes in place to help with work adjustment (O):

My husband, he was working and he was here to just guide me where to go, which courses do I need to attend, you know, to prepare for the exams and things like that. So I didn't go through much of the trouble to be honest. [OMG5_NON]

However, for some, family circumstances actually added to levels of stress and anxiety (M):

…my wife was finding it a bit difficult here, because she was feeling lonely. My son, he didn't have many friends, but slowly but surely we have some friends. [OMG4_NON]

On occasions, retention was hindered due to family circumstances (O) (evidenced in the retention data):

Well no, she's decided, I think because of the family reasons she has decided to leave the country and go back to Middle East where her husband is based at. [Supervisor_OMG2_POD1_INT2]

Having individuals that acted as 'mentors' outside of work also gave initial insight and reduced levels of stress usually encountered when starting a new position in a new country (M). This meant that they could focus on their work and improve performance (O).

…my dad is also a doctor, and he had trained a lot of consultants who are already in the UK as well. So by the time I arrived, those people kind of just sort of like under their wings and kind of mentored me and helped me understand the system and make a transition to the system….And even when I got this job, I could focus on just the job, you know, and get the job done, and negotiate it and concentrate on the training and all that, so I just could focus on medicine and getting better at it. [OMG1_NON]

External support was particularly important for OMGs who did not have any sort of support network and had faced negative experiences in their work.

The individual below acknowledges different circumstances and the importance of having support during stressful situations (C). Unfortunately, some colleagues were not as resilient (M) and did not manage the stress they faced (O):

I mean there was somebody who took work at about the same time I did, who later killed himself within a few months of that. I think the whole stress of the situation at that time just broke him really. I did have colleagues who were jobless for years, two, three years before being able to get their first medical job, and of course some people were in a lot of debt. You know, had people who, extended family members threw them out of the house because they were tired of them. So I just wonder how it would have been if I didn't have family around me and all that, you know. [OMG1_NON]

Individual circumstances – length of time in UK:

Another factor that impacted on initial adjustment was how long the OMG had been living in the UK prior to starting work (C). The individual below had little time for adjusting to the new culture:

I moved right before starting my first year as F1, so like literally a couple of days before. [OMG9_POD1]

In comparison, the OMG below had been living in the UK for over 10 years:

We came back to the country in 1993 and then 1994/95 we've been here in United Kingdom since then. I had not started working initially when I came to UK. It was only after the youngest was born here in 1996. And then we lived opposite St

Thomas's Hospital so I did an extended attachment in dermatology over there. And that helped me fulfil my requirement for taking the exam back in Pakistan. So I travelled back to take the exam in 2001. [OMG5_POD1]

As is highlighted here, this individual faced less stress (M) as they were already living in the UK when they decided to take her examinations. Over time, she was able to acquire necessary knowledge, both clinically and culturally, before starting work. This also meant that her family were more likely to be adjusted.

Incentives:

OMGs that attended POD were practicing at different levels and had managed to secure their positions in a variety of ways. Their incentives for moving to the UK and working in the NHS (C) impacted upon their motivation for career development and progression (M). Where this was the main focus, this led to resistance in developing a social network at the training level (M) (section 7.3.2.7):

I am really worried when it comes to my career. So the rest of the things, social part, that's not a problem, I can live without. [OMG7_POD1]

Some hoped to build a career and life within the UK, whilst others just wanted the experience of working in the UK:

The reason is mainly that I want to pass my postgraduate exam; especially for applying the knowledge back home when I finish the postgrad exam. I plan to go home. [OMG11_POD1]

Retention was unlikely if their desires for moving to the UK were not fulfilled (O):

So there's no personal development because you are not monitored…It is not only the money. I know I have good salary here, but I don't care about the salary at all. [OMG10_NON_INT2]

…if I get into the training programme I would stay back, but if I don't get into the training programme then probably I would think of going back after a year or two. [OMG12_POD1_INT2]

One individual spoke of a friend who returned to his home country due to a lack of career development (O):

He said I'm doing a job that's more junior than I'm used to do, more techniques but he does not have access to that kind of training or some kind of advantage that he wants. He can watch them. Money wise, life here is more expensive… it's not very advantageous and then he found himself, okay, I'm leaving here, I'm going to go

back. If you want just to be working in UK and work in whatever, it's fine, but if you want to achieve some excellency, you struggle. [OMG7_NON_INT2]

However, some OMGs were motivated to stay and learn regardless of career development (M):

I want to really work and I want to give my 100% capacity, and I want to take 100% of things from here. So that is my target…try whatever the level. [OMG10_NON]

This motivation to learn was important during POD (M). As illustrated at the training level, OMGs had to see the benefit of participating (C):

It was useful for me, especially in this trust and with like we had all the simulation and stuff, because the communication stations where we had to role play, all those were like useful for me. Because we applied for the training post here and these things are very important in the interview part. So I found that really useful for me. [OMG6_POD1_INT2]

Those who attended POD also wanted a certificate so that they could use it to illustrate CPD. It was proposed that recognition should be given from a regional level.

This section illustrated that Individual differences inevitably played a role in OMG transition. More focus was placed on these differences during this evaluation than in the initial middle-range theories presented in Chapter 4.

7.3.3.3 Role identity

Loss of status:

Those who had previously been practicing in higher positions, often older in terms of age, and who have had to take more junior roles, sometimes struggled in their transition:

…often if they're not in non-training posts they may actually have worked for 15 years in another country, come over here and the post they've been allocated, a foundation year two post, but actually they've got CMTs who are aged 26, 27 who technically are their senior. And actually their ability to manage in this country is more junior, that can cause problems. [Supervisor_OMG13_POD1]

The feeling of being 'deskilled' (C) led to increased stress (M):

I feel I am totally underutilised, totally, totally, I can do more work than this specialty and I think that the Trust or even the university might use of me more than what I am doing at the moment, but no-one sees, it's too blind. [OMG7_NON_INT2]

Where OMGs were resistant to a new role (M), this sometimes led to performance issues (O):

Sometimes the attitude can interfere with clinical care and become a bit unprofessional. [Supervisor_OMG8_POD1]

Feeling that they did not have the ability to practice at the same level they once did, where they perhaps excelled, may have also decreased self-esteem and self-efficacy (M):

By that stage the nurses didn't even trust him with practical skills. Even though back home he was actually quite senior…that will also eat away a little bit on your confidence initially, if that is something you normally can rely on and suddenly you're not quite as good at it because the equipment is different and the procedure is done slightly differently…she mentioned it a couple of times. [Supervisor_OMG13_POD1]

These feelings of decreased self-esteem and self-efficacy impacted on interactions and retention (O):

You feel shame of asking, you don't know how to explain your feeling. [OMG11_NON]

…you start doubting yourself, say oh what's this now, am I safe, shall I continue on this work or not? [OMG6_NON_INT2]

Some were motivated to learn and so accepted their new role (M) (due to incentives or personality discussed previously), which was important for their work adjustment (O):

When I arrived and I started as a registrar I said well but I don't know what the foundation are doing really, you know. I asked to move a ward and tried to do every kind of jobs just to let me know how is it - if you come and if you start working as a specialty doctor, registrar or consultant and you don't know which, or how do the junior doctors work here, you are missing a part of the picture. [OMG11_NON]

Support in training helped OMGs to recognise the differences in practice and helped them to combine their old and new skills (M) (discussed at training level). UK graduates could also learn from OMGs. This greater level of cooperation likely lead to a new professional identity and supported performance for both parties (O).

It was also important that during the intervention that older OMGs were matched to 'buddies' that were of a similar age, otherwise they may have been resistant to the process (M):

And I think having an age range was a good thing because obviously, she was similar age to myself, she's got a grown up family. I know I had a buddying scheme when I was at Durham doing my medical training, and my 'buddy' was a similar age to my daughter really. [Buddy_OMG2]

Loss of identity:

Many Trust Doctors in comparator Trusts felt that they did not have any responsibility, or what was expected of them, in their new role (C):

> *...but you do not have a specific responsibility and even when I spoke with the programme director, he said to me, you just have to go with the flow and if the registrar wants you to do something you have to do it, and just say okay…I don't know what's really asking me to do and what are my limitations, so I was not really comfortable with what I was doing, what I am doing. [OMG7_NON]*

This feeling that they no longer had a role identity not only lowered self-esteem (M), but increased anxiety as they were not comfortable in what they were doing (M). This highlights possible patient safety issues (O).

Very much linked to incentives, a lack of, or decrease in, role identity or status was found to impact intervention success and overall transition (in support of the initial theory).

7.3.3.4 Preparedness for practice and expectations

Variance in how prepared OMGs are for practice:

Differences in medical practice between the UK and other countries were a big focus in discussions with all groups of participants (C). OMGs from AH largely illustrated insight into these differences (M), making their adjustment to new practice likely (O):

> *There's a lot of things that are different here…I kind of have to think twice or merge my existing knowledge and learn more, so that makes it difficult. [OMG4_POD1]*

As discussed, OMGs came in having different levels of experience both outside and within the UK. Some OMGs had a great deal of insight (M) from experiences in their own country and in the UK (C). As a result, they faced less stress (M) and were able to make quicker work and cultural adjustments (O):

> *I had done clinical attachments when I was in medical school, so I had attachment down in Scarborough. I did medical school in Bulgaria and that course was in English. I did an attachment for a few weeks here I knew what is expected of me. Every summer I used to visit UK. So I was familiar with everything here, it was not a surprise for me when I came and I started working. [OMG6_POD1]*

Some individuals did not have sufficient insight into how different practice would be (M):

> *The responsibilities junior doctors have here. I didn't have any responsibilities in my country, so that was really hard and still is. And the rhythm of the things happening, it's really fast. I was only shadowing my consultant in my country, I was never allowed*

to do stuff myself, or take any decisions. I knew that it's going to be hard. I knew that it's going to be different. But I didn't think it's going to be this hard. [OMG7_POD1]

The lack of insight (M) was largely caused by differences in cultural practice (C), which was evident in OMGs from both AH and comparator hospitals:

Her experience of psychiatry was in the asylum system, which is quite different from what we do in the UK…it was like somebody who was let's say educated in the system of 1980s suddenly finding themselves practising in 2000. [Supervisor2_OMG8_POD1]

…they complained that you took blood from them twice and you shouldn't have done it, and I told him, yes of course I took blood from them twice, because nobody had explained me that this should be the bottle for taking the blood transfusions, for making blood transfusions, and in Greece it's a different colour and how I should know if nobody explain me, how I should question? [OMG9_NON]

A lack of insight led to a great deal of stress (M) and adjustment took longer (O):

I wasn't at the same level as my peers in some aspects. Even if you're saying the right things and your mind is working all right, it's just because that structure's not in place. I find that that is still a problem for me. [OMG9_POD1]

I mean he's not made great progress. He's had a couple of issues. He's not managed to get through his RCB so I think he's still struggling…he does seem to have fallen back a little bit this year. He's not going to complete the foundation programme at the end of the two years, he might need extra time. [Supervisor_OMG9_POD1_INT2]

Interestingly, he was a gynaecologist and tried to do general practice training, and he was just, he actually had to leave the scheme, he was totally disrespectful and women were not the same breed. [Supervisor_OMG6_POD1]

Supervisors at AH stated that so long as clinical knowledge was evident (C), they supported OMGs to gain insight about cultural differences (M). OMGs usually progressed (O). However, in their experience when too much clinical knowledge was lacking, some were unable to progress:

One, we did push him into middle grade with the appropriate support, but still did not progress as well as they should be. Some will move on to middle grade within two to six months, some will never move to middle grade, and then we will honour their contract for one year before letting them go. [Supervisor_OMG6_POD1]

It was felt that senior doctors would face the most difficulty:

…they come and they have not worked in the NHS system, they come and work as a senior doctor. So for them to, it will be completely different from wherever they come from. [Supervisor_OMG1_POD1]

POD provided initial information to OMGs that aimed to address a lack of insight (M). However, many of the clinical differences, and new ways of learning and practicing, had to be managed once on the wards (C). This caused initial stress (M):

> *In my university we did more knowledge based learning, so like the clinical and practical aspects I had to learn more on my own here. So there was like a steep learning curve. But it's fine; it's just again more stressful at the beginning…we did things in groups for example, and basically on more like simulations rather than on real patients. Also my year, my medical school is only four years, whereas here it's, like in Europe it's five or six years... [OMG4_POD1]*

In addition to this initial stress there was also a negative impact on self-esteem (M):

> So like in Italy, medical students, doctors in general don't take bloods, and they don't cannulate, for example. I mean this, especially at the beginning, was kind of one of the biggest things, because there were some issues with cannulas and things, and these are the very basic things that you have as an F1 to do, and you get asked multiple times to do these things. So if you don't have those skills, people kind of look at you and be like well, what's going on, like why can't he do these things which are in reality quite simple, like I mean now I've learned how to do them and I can cannulate quite well and take bloods very well. (OMG9_POD1)

Clinical skills such as cannulisations were lacking in the majority of OMGs in this project, also noted in the performance data and at the training level (O). OMGs were expected to know a basic level of clinical knowledge that was adequate for the level that they were practicing. When this knowledge was lacking (C), the focus of the POD sessions was sometimes lost as OMGs sought to acquire clinical knowledge rather than wanting to learn about the non-clinical skills that POD focused on (M). During the simulation stations, for example, OMGs did not always engage in the communication aspects as they wanted to learn about the clinical skills that were identified to be lacking in their practice. However, this was still important in raising their awareness and highlighting potential barriers to practice.

Variance in OMG communication skills:

Certain levels of language and communication skills were also expected prior to the OMGs starting in the UK, however communication levels varied between OMGs (C). Assumptions were sometimes made from the organisational level (discussed previously) that PLAB and other assessments meant that OMGs are prepared for practice. However, it is evident that they are not always.

From observing POD, those from EU countries seemed to face more language problems (C). This may be due to the fact that they did not need to take the PLAB test. This was supported by supervisors:

> *I mean you do find probably the English skills are better from international students I would guess. Not necessarily, but possibly because they were taught in English more than most European doctors. [Supervisor_OMG13_POD1]*

Many examples were given where OMGs from the EU were using foreign terminology when talking with patients. In contrast, some excelled (C):

> *I think she has got more confident with time, I mean her English is fantastic, there's no communication issues there. [Supervisor_OMG8_POD1]*

POD was successful in increasing the insight of OMGs regarding what areas of communication they needed to address (M), both EU and international graduates:

> *I think the communication is one aspect I am looking forward to have some more coaching in. I am trying to - if there are some good courses coming in I would definitely enrol in it. [OMG12_POD1_INT2]*

Expectations of OMGs:

Holding high expectations about practice in the UK (C) caused some OMGs to face disappointment (M):

> *There were so higher expectations from my side that led me really to feel very disappointed in the work... [OMG7_NON]*

> *...we think that the UK it's a very civilised country with high professionalism and I would expect that they would be very polite to me at the beginning, that they would show me around, that everything would be better than Greece, but this has not happened. It was like falling down from my cloud. [OMG9_NON]*

Others felt that they were prepared to start practice and did not expect to face such difficulties (C), which impacted upon their self-efficacy (M):

> *I thought I was well prepared. But maybe the accent or maybe because when you go into a system that is ongoing, it's working, they cannot stop. So you have to try and you struggle really. I was feeling I was not understanding, so I was not having control, I was not having everything under my control. So I was feeling my self-confidence was very poor in that moment. So everything was kind of black, because I thought I was not going to be able to continue like that. [OMG11_NON]*

Had they sought the necessary information themselves before arriving (C), it may have increased their insight and hindered resulting stress (M):

…I had a role to play in that in the sense that probably I should have done my homework extensively, which I probably lacked. The fact is I came here totally raw and I didn't know it, so part of the thing is mine, contributed by my distinct lack of awareness as well as lack of support. [OMG2_POD1]

I had no clue what revalidation is. I found out I had four months to go to get revalidation and get an appraisal. I started freaking out. Partly it is my fault as well, I should have Googled and found out what is expected of me. [OMG7_POD1_INT2]

Many did not expect to begin practice straight away (C), causing a great deal of stress (M) and highlighting patient safety issues (O):

When I joined the NHS, that was the worst day I had in the UK. I had no experience. I wasn't expecting that I'm going to start working on the first day…my first day was like hell on earth for me. I didn't know how to bleep! I didn't know how to bleep a person. So I had a very difficult time. [OMG3_NON]

These expectations may in part explain why a high number of OMGs left their work (O) (evidenced in retention data).

Supporting the findings from Chapter 4, level of clinical knowledge, communication skills, and experience, were found to impact upon adjustment to practice. Meeting expectations was also found to be important in the initial phase of transition.

7.3.3.5 Capacity to change and identification of needs

Similar to the impact of role identity, OMGs needed to have the capacity to change (C) if they were to adjust to a new culture and way of practicing medicine (O). Those who were able to identify their needs and were willing to sacrifice time (C), had better insight and were motivated to do any necessary training that would develop their skills (M). Supervisors highlighted the importance of this:

So I felt I was going to have the challenge of having to change her to the UK system, one, and two also change her to the practice here in the UK…she told me differences [between the NHS and her healthcare system] right up front, right from the beginning, so I felt at least I got where she was, and hopefully I could take her to where she needed to be. And secondly she seemed quite keen to learn, because not necessarily every junior doctor that comes to you is keen to learn. But she was really willing and open to learn, which was good. So I just felt there were ingredients here to work with. [Supervisor2_OMG8_POD1]

…he was very open, which was really helpful. He was able to say I haven't done this, I don't know, my experience at medical school was this…and for instance he recognised he didn't know Calgary Cambridge for communications. So I said right

we're teaching the medical students it this afternoon, go. He was straight in there getting involved, learning from it and then applying it. [Supervisor_OMG4_POD1]

This positive attitude to change led to greater insight and adjustment (O):

She improved quite quickly, more quickly than I thought she was going to, and that was really very good to see - because I've had another doctor after her, and they haven't improved as quickly. [Supervisor2_OMG8_POD1]

…I am happy that if I had any problem and someone raised and said, pointed it out to me, so when I am going wrong, there is the problem. Because of that I had a chance to adapt to the system very quickly. I accept that, with that hard time and with the problems I met and everything, I am much more comfortable because of that. So I really appreciate that. [OMG10_NON]

Despite having the capacity to change and willingness to adapt to a new culture, some OMGs felt that their adjustment was hindered by a lack of support:

...so I have good intentions, but good intentions are not enough unfortunately. I start speaking up and even people weren't bothered about me speaking up sometimes, but I kept on going. [OMG7_NON]

This illustrates the need for all contextual levels to be working together to support OMG transition. The above individual was motivated to learn (M), however was not given the opportunities at training level.

Where OMGs did not have the capacity to change (C), they were likely to be resistant to feedback; both during the intervention and back in practice (M):

There are sometimes cultural issues around some cultures accepting blame, that kind of thing. Mistakes are seen as terrible things as opposed to things to learn from, so there's a tendency to cover up rather than discuss, and admitting that you're not right all the time, for some, problems arise. [Supervisor_OMG6_POD1]

People were a bit sometimes overcritical [during POD], we had like an argument a bit as well, because I thought, because I worked already for a year and I know how it is in real life, and they wanted to be perfect, and they were like, the judges kind of thing. [OMG8_POD1]

However, through experiential learning in the intervention (POD), transformative learning took place and insight increased:

It was interesting to see how it should be done and how it is in real life. It was a learning experience, yeah, it was definitely. [OMG8_POD1]

Having a capacity to change, and therefore insight (M), was also noted by supervisors as being important for those attending POD. Reflection has to be taken forward and applied to practice (O). This is why support in training is crucial alongside individual capacity to change:

> *I mean I think you need that insight and reflectiveness to really get the benefit from the overseas doctors programme, because it is just a few days, so you've got to think about it and take it forward, and I think he's really done that. [Supervisor_OMG4_POD1]*

> *Well, it's not just a reflection; it's putting the reflection into practice. I think she's reflected a lot, but making the next step and making changes to her life, that's really difficult. [Supervisor_OMG11_POD1_INT2]*

The findings here link to the training level, which stated OMGs have to understand the need for the training if they are to engage. This is important if they are to have the capacity to change, effectively learn and transfer this into practice (also supporting the initial middle-range theories).

7.3.3.6 Summary of individual factors

OMGs themselves, as well as the organisation, have the responsibility to ensure that they are able to adjust to working in the UK. Whilst training and support can be put in place by the organisation, the individual factors highlighted will likely impact upon success. Individual differences, capacity to change and preparedness for practice were found to have an impact on OMG adjustment to the NHS; both their learning and transfer into practice. Perceived barriers, expectations and role identify were further found to facilitate transition.

7.4 POD developments

This section highlights key developments of POD following the findings discussed in this chapter. Evaluation of the refined intervention is presented in the next chapter.

- The intervention was implemented earlier (August) and spread across 4 weeks, the purpose being to ensure ongoing support and overcome difficulties associated with attendance.
- Repeat sessions were run to ensure OMGs could participate.
- Through the development of POD over the course of three years, the planning team felt that the Trust would be able to implement the training themselves. Internal educators from AH were recruited to implement some aspects of the communication skills training. An expert trainer was also recruited through HEENE It would not have been sustainable to continue using an external group each year due to its cost, however it was ensured that the essential topics were covered (for example, breaking bad news, SBAR, doctor patient relationships, colloquialisms etc.).
- A formal needs assessment (OSCE style) process took place prior to POD. This was to highlight the need for specific training. Feedback was given to both OMGs and educators as part of their PDP.
- External educators from the GMC were recruited to provide key information concerning GMC guidelines that was reported to be lacking, for example ethical issues, insurance, unions etc. (success also noted in HEENE and WtUKP inductions).
- Peer support was removed due to lack of attendance.
- Simulation was removed as it was felt role-plays were just as effective in improving communication, whilst also saving resources.
- An OMG from the POD planning team attended most sessions to share his experiences and facilitate discussions.
- Buddying was implemented earlier; the speed dating session took place during the induction programme. OMGs who attended POD the previous year were recruited as 'buddies'. They were partnered based on current post, culture etc. The education department oversaw the admin side of the buddying system (e.g. emailed names and contact information following the speed dating session). It was recommended that all OMGs that could not attend POD were offered a 'buddy'.
- A Trust Doctor tutor was implemented. The Trust Doctor tutor was an OMG himself who took on a 'buddy' role, particularly with regard to career progression, for all Trust Doctors.

- Being better able determine when OMGs were starting work was needed, ensuring engagement with both the induction programme and buddying. Therefore, a more robust recruitment system was created; linking HR, the education department, the Trust Doctor Tutor, and supervisors.
- Increasing cultural awareness within organisation was also sought (for example, through the dissemination of POD information, findings from this project, involving educators and supervisors).
- Increasing awareness outside of the programme was further sought (it was largely myself doing this – sharing best practice, using local resources etc.).

7.5 Summary and conclusion

The findings from this first cohort support and develop the majority of the middle-range theories that were presented following the realist synthesis. The necessary individual, training and organisational contexts must be working together in order to ensure OMGs make successful adjustments in their transition process (evidenced in performance, retention and career progression outcomes). General adjustment was noted as an outcome that was not evident in the realist synthesis (emergent).

The focus at AH was providing ongoing support to OMGs, as well as a specific intervention (training programme). Establishing strong support networks and ensuring OMGs felt welcomed and supported was critical to adjustment. Whilst the organisation and training level determined the level of support given to OMGs, the programme theory places importance on the role of individual factors; explaining why some OMGs may have been more resilient to difficulties faced in their transition than others. The use of the non-intervention group also explored the impact of negative experiences on overall transition, particularly retention and performance. Whilst regional interventions were in place, they were fairly short in length and failed to overcome many of the transitional issues that are highlighted.

Chapter 8 Findings from cohort 2: Programme theory refinement

8.1 Outline

As with the previous chapter, this chapter begins by exploring the post intervention outcomes of cohort 2 (POD2); including questionnaire data and further exploration of performance data. Retention rates and career progression of the intervention group and comparator group is presented. Overall evaluation findings, including interview data from cohort 2, the comparator group, and experts is then presented. Context (C) – Mechanism (M) – Outcome (O) configurations are again highlighted within the text. The focus of this chapter is ultimately refinement of the programme theory and highlighting any emergent and analytic themes. Replication of prior themes from Chapter 7 has been avoided as much as possible. Data saturation was reached by the end of the cohort 2 evaluation, with no new theoretical insights emerging. Exploration of the programme theory with the 'experts' will be discussed throughout as this helped to validate the programme theory. The refined programme theory, and resulting intervention, is put forward. The chapter concludes with a summary of the findings from cohort 1 (POD1) and cohort 2 (POD2) (synthesis of data), and how these findings inform the programme theory.

8.1.1 Summary of key findings presented in this chapter following synthesis of cohort 2 data

- Findings from cohort 2 support the theoretical explanations offered in cohort 1, the programme theory supported with minor revisions. Experts also validated the theory.
- Retention, career progression and performance outcomes presented in this chapter support the theory that the Programme for Overseas Doctors (POD) positively influenced Overseas Medical Graduate (OMG) transition at Amity Hospital (AH). Interestingly, incident rates (including Serious Untoward Incidents) involving all OMGs in the hospital dropped following POD2. Analysis of the Educational Governance (EG) data further suggested that OMGs were performing better than UK graduates in the hospital.
- Senior staff and the enthusiastic planning team drove POD. Engagement with POD and support for OMGs increased further throughout the hospital following POD2. Relationships formed organically and an understanding about OMG transition was

evident from all levels. The high number of OMGs at AH influenced this (around 37%). This support helped to overcome initial negative experiences that may have hindered the transition.

- Despite its success, practicalities involved in recruitment and implementation hindered the development of POD, for example, being unable to identify OMGs beginning work in the organisation. Resources outside of AH, such as information packs, were also readily available but were not being utilised due to a lack of dissemination across Trusts.
- As discussed in chapter 7, local level implementation was most successful, however it needed to be realistic, taking into account resources and workload. Ongoing support increased workload for peers, supervisors and educators. It was suggested that regional or national level involvement could support implementation. However, individual Trusts still need to take ownership of the problem, not relying on regulatory bodies to address the issue. AH was willing to invest fully in supporting their OMGs, recognising this is a long-term commitment; long-term interventions were found to be most beneficial.
- OMGs themselves had a personal responsibility in ensuring that they made the most efficient transition as possible. Individual factors affected engagement with interventions, learning and transfer to practice.

8.2 Quantitative data and outcomes

Like Chapter 7, this section presents the quantitative outcomes of varying aspects of the intervention that fed into the overarching programme theory (including questionnaire data, performance data, retention rates and career progression).

8.2.1 Questionnaire data

Although the sample is small and the data was based on self-assessment, the findings from the Wilcoxon Signed-Rank Tests, presented in Table 11, highlight that there was a significant difference in self-efficacy; Z = -2.677, p = .007. The mean self-efficacy score for the group increased from 3.5 to 4.2 post- intervention (5 being the highest score). This suggests that POD2 positively influenced perception of self-confidence levels (M).

The Wilcoxon tests further highlight that there was a significant difference in pre- and post-self-assessed culture scores; Z = -2.316, p = .021. The mean score for the group increased from 3.5 to 3.9 post- intervention (the highest possible score being 5). This suggests that POD2 positively impacted upon self-assessment of cultural adjustment (O).

Table 11. A table illustrating the mean scores (and standard deviation) and P values of the evaluation questionnaires given pre- and post- intervention in cohort 2 (n=9). All were assessed on 5-point Likert Scales, apart from the PPOS which uses a 6-point Likert scale

	Pre-POD	Post-POD	P value
Self-efficacy (good practice)	3.5 (.59)	4.2 (.23)	**.007***
Patient-Practitioner Orientation Scale (PPOS)	4.3 (.45)	4.3 (.45)	.905
Patient sharing (PPOS)	4.2 (.63)	4.2 (.31)	.952
Patient caring (PPOS)	4.5 (.41)	4.3 (.49)	.372
Culture	3.5 (.52)	3.9 (.33)	**.021***
Communication	3.7 (.63)	3.9 (.42)	**.034***

** = statistically significant p<.05*

There was a significant difference in pre- and post- communication scores; Z = -2.120, p = .034. The mean score for the group increased from 3.7 to 3.9 (the highest possible score being 5). This suggests that there was an increase in understanding of communication in UK practice (M). As noted in Chapter 7, caution was taken not to generalise the findings as indications of improved knowledge and performance (limitation of self-assessments).

It is interesting to note that the mean score for patient caring decreased following the training (the mean score decreasing from 4.5 to 4.3). Other than self-efficacy, there were also individual negative ranks (individual questions were scored lower) for all competencies being tested; suggesting some individual scores decreased post- intervention. As discussed in Chapter 7, this may be explained through an increase in self-awareness and expectations following training (M). Increased understanding about living in the UK and practice in the NHS may have led to accurate perceptions about their current practice and adjustment (M).

8.2.2 Performance data (Educational Governance data) (O)

As described in Chapter 5, there was difficulty in monitoring doctors working at AH, however, the data retrieved was as accurate as was possible. An estimation of 108 (37.1%) OMGs worked at AH at the point of POD2 data collection (Table 12).

Between August 2015 and June 2016, a total of 106 incidents were reported at AH (81 individuals in total). Eighty-five incidents involved UK graduates (60 individuals) and 21 incidents involved OMGs (21 individuals). As with the findings in Chapter 7, this does not illustrate a difference between UK and non-UK graduate performance given the high number of OMGs working in the hospital. Overall, the number of incidents reported for all groups had nearly halved. Of the 21 OMGs involved in an incident, four had attended POD (19%) and 17 had not (81%). One individual had attended POD1 and three individuals had attended POD2. The number of OMGs that attended POD was too small to infer a difference between non-intervention and intervention groups, however exploration of the data was of interest (highlighted below).

As Figure 20 shows, OMGs who attended POD were involved in three types of incidents. These were labelled as a medication error, a complaint, and two SUIs. No further detail was documented on the database, however, all were resolved following engagement with supervisors. OMGs that did not attend POD were only involved in four types of incidents, although some were quite serious incidents (including SUIs, prescribing errors and concerns). UK graduates were involved in all types of incidents.

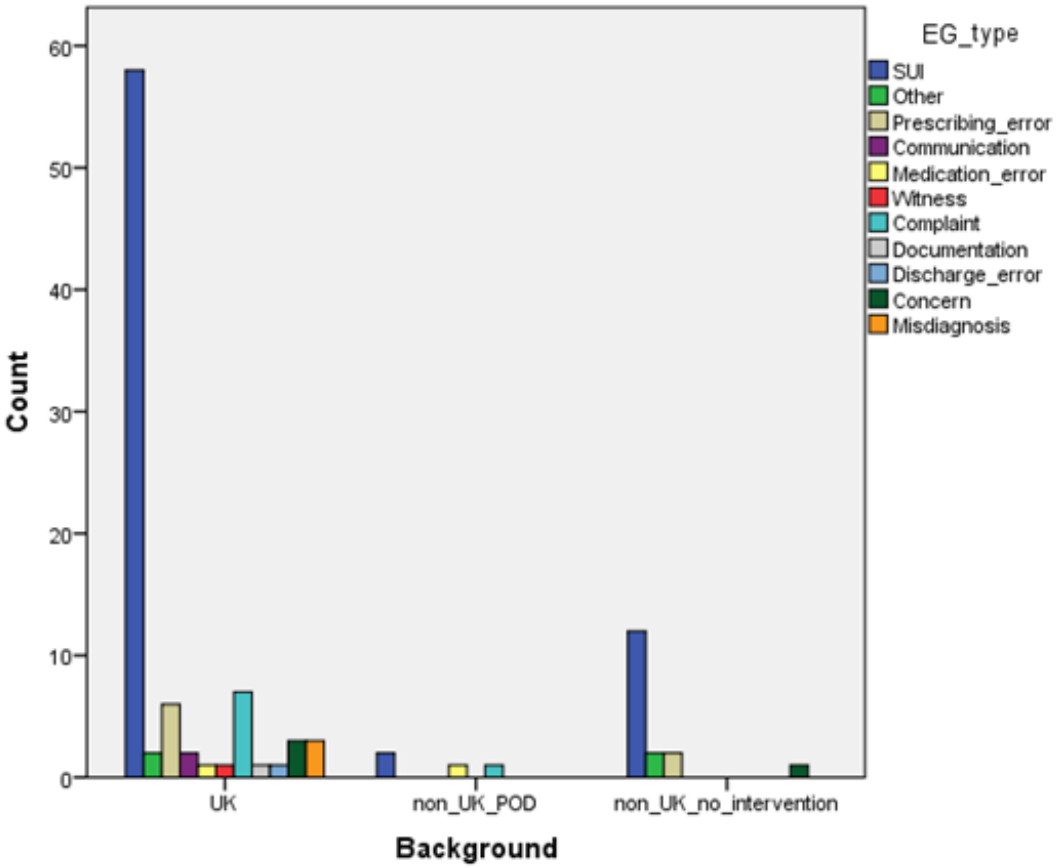


Figure 20. Graph showing the types of incidents that were reported between August 2015 and June 2016 in accordance with the Educational Governance data (EG)

A high proportion of all OMGs were in training posts (Table 12), supporting findings from Chapter 7 that career opportunities and progression of OMGs was evident.

Table 12. A table to illustrate the number and grade of OMGs working at AH in June 2015

		N	Percent
Intervention	Yes	11	10.2%
	No	97	89.8%
	Total	108	100.0%
Grade	Foundation	7	6.5%
	Specialty Training	42	38.9%
	Core Training	18	16.7%
	Trust Doctor	21	19.4%
	Clinical Fellow	9	8.3%
	GP Specialty Training	3	2.8%
	Registrar	8	7.4%
	Total	108	100.0%

Eleven (10.2%) OMGs had attended POD training. 28 (26%) OMGs had been involved in an incident (Table 13). In contrast, 74 (40.4%) UK graduates were involved in an incident.

Chi-square tests illustrated that there was a significant association between where the doctor graduated and whether an incident was reported, $\alpha = -6.282$, $p = .012$. As Table 13 illustrates, it was expected that UK graduates would be involved in fewer incidents and OMGs would be involved in more incidents (if there were no association). Instead, the findings suggest that OMGs were performing better than UK graduates were.

Table 13. Chi-square test analysis: Cross-tabulation of place of graduation and the association with incidents reported (data for all junior staff was collected)

	Graduated in UK	**Graduated Overseas**	**Total**
Number of incidents reported	74 (40.4%)	28 (26%)	102 (35%)
Expected number of incidents reported	64.1	37.9	102
Number of no incidents reported	109 (59.6%)	80 (74%)	189 (65%)
Expected number of no incidents reported	118.9	70.1	189
Total	**183** (62.9%)	**108** (37.1%)	291

Using the numbers obtained, it was estimated that 43.3% of all OMGs at AH were involved in incidents during cohort 1 data collection and 27.8% of all OMGs at AH were involved in incidents during cohort 2 data collection. This suggests that incident rates involving OMGs (including both POD and non-POD) dropped following POD2. Given that only 11 OMGs from the data set had attended POD, the findings therefore suggest that contextual factors outside of the POD intervention itself were likely to have played a role in OMG performance (supporting findings presented in chapter 7).

8.2.3 Retention rates and career progression post intervention (O)

Table 14 illustrates that all of those that attended POD at AH remained working in the hospital one year later. All but one of the OMGs in this group had progressed in their careers (or were in the process of applying). Four of the attendees had gone on to secure a training post, one had secured a registrar post, and the other was working as a consultant. Although numbers are small, this does suggest high retention and career progression.

Table 14. Table showing career progression and retention rates of OMGs from AH one year after POD (cohort 2)

Cohort 2 – Intervention AH		
Grade started at	Retention after 1 year	Grade after one year
Foundation year 2	Remain at AH	Applying for Specialty Training
Foundation year 2	Remain at AH	Specialty Training
Trust Doctor	Remain at AH	GP Specialty Training
Trust Doctor	Remain at AH	GP Specialty Training
Clinical Fellow	Remain at AH	Specialty Training
Clinical research fellow	Remain at AH	Registrar
Trust Doctor (Specialty Training equivalent)	Remain at AH	Consultant

Table 15 illustrates that OMGs working at AH, who did not attend POD, had remained in their posts one year later. They either had progressed in their career or were applying for training. One individual from CH left. One remained in training whilst the other remained as a Trust Doctor. Small sample sizes hindered further exploration, however the findings do suggest that retention and career progression was limited.

Table 15. Table showing career progression and retention rates of OMGs from comparator group (non-POD) one year after POD (cohort 2)

Cohort 2 – Comparator group			
Grade started at	Recruited from	Retention after 1 year	Grade after one year
Trust Doctor	AH	Remain at AH	Trust Doctor applying for Specialty Training
Trust Doctor	CH	Left CH	N/A
Trust Doctor	CH	Remain at CH	Trust Doctor
Specialty Training	AH	Remain at AH	Specialty Training
Clinical Fellow	AH	Remain at AH	Specialty Training
Core Training	CH	Remain at CH	Core Training

This section highlights that the initial training outcomes of POD2 were positive (as stated in Chapter 7, not to be generalised due to small population and use of self-assessment tool). It is interesting to note that only self-efficacy significantly increased for both cohorts. Retention rates and career progression of those who attended POD (and those who did not) at AH was high. OMGs from comparator hospitals illustrated poorer career progression (limited due to very small sample). Incident rates of OMGs also dropped by a high percentage between POD1 and POD2. The findings also suggested that all OMGs at AH were performing better than UK graduates. As with Chapter 7, these outcomes fed into the programme theory presented next.

8.3 Programme theory refinement – synthesis of findings

This section presents a synthesis of the findings from POD2. Table 16 highlights the demographic data of all POD2 participant groups that took part in interviews.

Table 16. Participant demographics and sample size for cohort 2

Cohort 2 (POD2)	OMG intervention	Supervisors	'Buddies'	OMG comparator
Gender	Female - 2 Male - 5	Female - 2 Male - 8	Female - 0 Male - 2	Female - 3 Male - 3
Grade	Foundation training (2) Trust Doctor (3) Clinical fellow (1) Clinical research fellow (1)	N/A	N/A	Trust Doctor (3) Specialty training (1) Clinical fellow (1) Core training (1)
Country where graduated	Nigeria (1) Pakistan (2) India (1) Romania (1) Sri Lanka (1) Greece (1)	UK (4) Non-UK (6)	Non-UK	Egypt (1) Greece (1) Sri Lanka (2) India (2)

Emergent themes were identified to refine the programme theory; however, these were minimal in cohort 2 data. The resulting themes instead benefited the programme theory through further exploration and explanations of the prior themes identified in the data from cohort 1 (analytic themes). The findings in this chapter therefore supported and developed the prior themes presented in Chapter 7. A summary of the developed contextual sub-themes identified in the programme theory are presented in Figure 21.

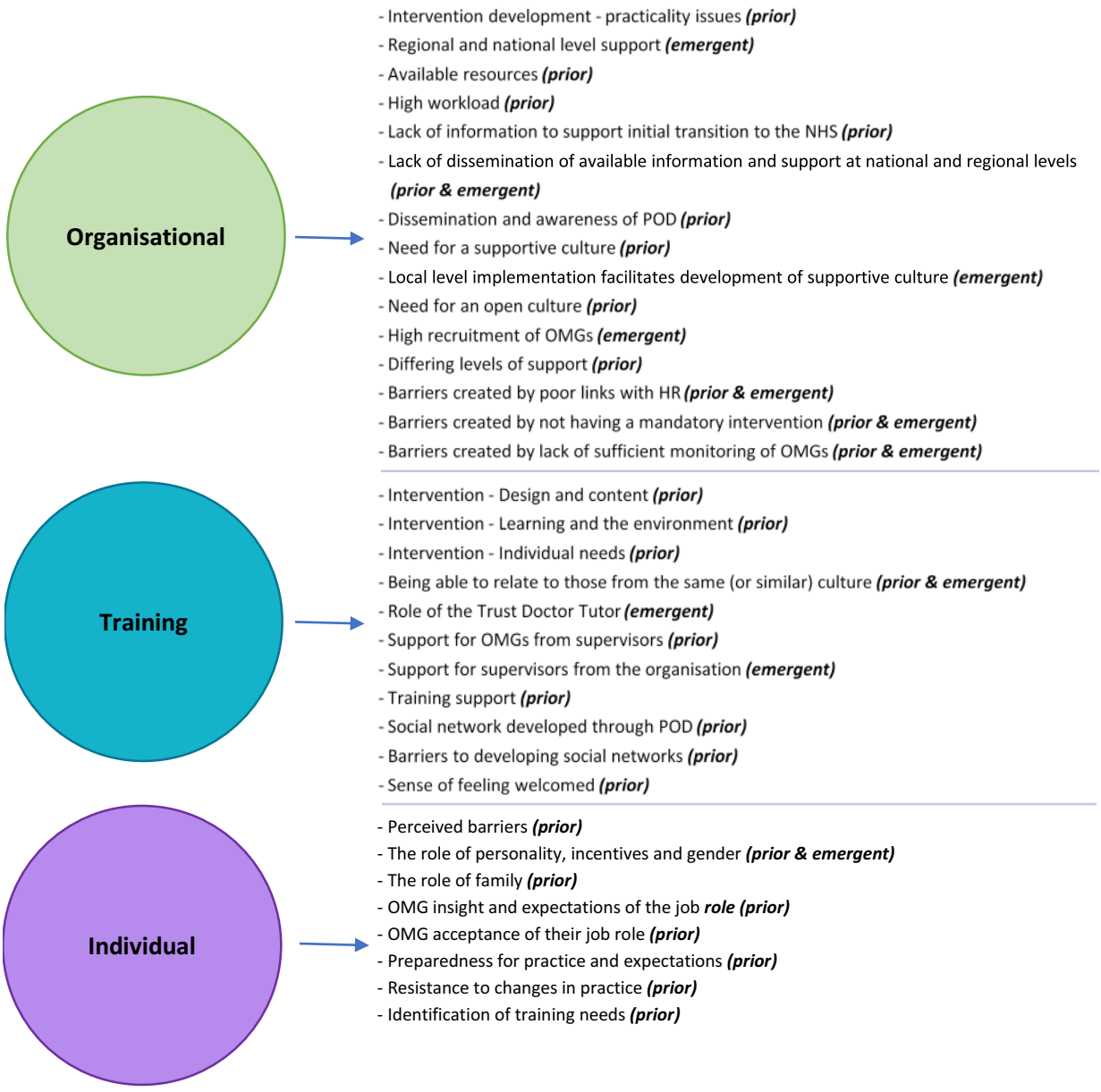


Figure 21. A summary of prior and emergent contextual sub-themes that were developed from cohort 2 findings. Analytic themes were evident at all levels (due to C-M-O configurations being developed).

8.3.1 Organisational context

Figure 22 illustrates the refined organisational contextual factors following findings from POD2 data collection. Each are discussed in turn.

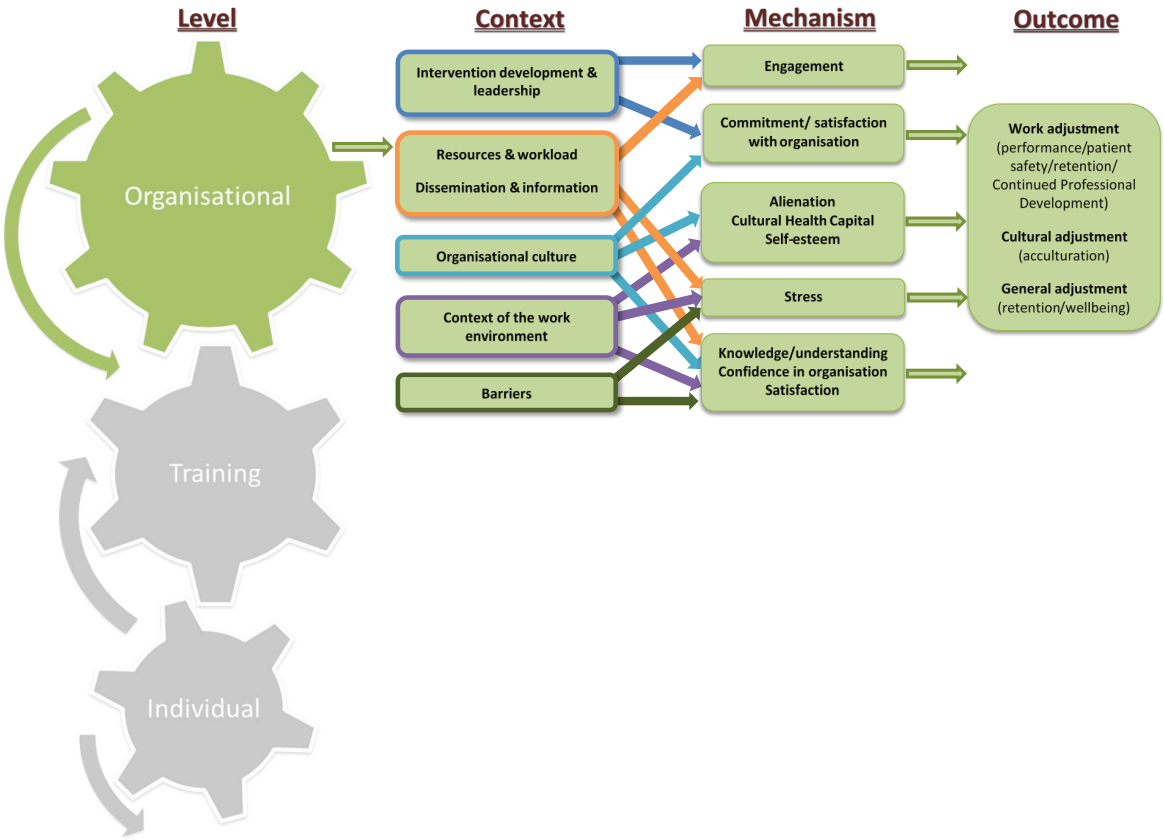


Figure 22. Refined programme theory; organisational level

8.3.1.1 Intervention development and leadership

Intervention development - practicality issues involved in implementation:

Practicalities involved in implementing POD hindered its development during cohort 2 (C), for example, the POD planning team wanted to implement a shorter version of POD (to be implemented in February as this was when the second biggest intake of OMGs occurred). However, this did not take place due to limited time. As a result, problems arose from OMGs coming into the hospital throughout the year who did not take part in POD, or not until much later:

> *…they start them at lots of different times, so doctors come to the UK for jobs that they source for them and they start them all across - there's no time when like 30 people start. [Expert 1]*

The same issues were evident with the need for a buddy:

> *It was one week before I started. Because the maximum stressful I was, was when I actually landed here on day one. That was the time when I was under maximum stress, because everything was new and there was nobody I could ask anything. So I think that's kind of the crucial period where the 'buddy' programme would really help, and would be a lot more significant if you have somebody at that stage. [OMG17_POD2]*

Despite acknowledgement that all OMGs beginning work at AH should have a 'buddy', not just those who attended POD, this did not happen. As a result, many OMGs were unable to engage in extra support. This led to OMGs feeling dissatisfied with induction and support that they received from AH (M). In discussions with OMGs who did not attend POD, they stated that the hospital should give more support so that doctors are working from the best of their ability from the beginning and so that they want to remain working there (O) (supported by performance and retention data). This was supported by experts:

> *[Amity] struggles with recruitment at times, and that's why they've put that programme in, because she has foresight. And [Blossomvale], I'm struggling. [Expert 2]*

Further issues arose due to the timing of POD2 (C). However, the intervention was spread out across a number of weeks, and each session was running twice, this benefitting attendance (M). August was also not a good time for educators at AH to deliver sessions due to the new intake of junior doctors, however it was felt that this was the best time to support OMGs. OMGs were able to use study leave to attend, however it very much depended if they were given approval to attend (see section 8.3.1.3). POD candidates wanted to attend (M) as they felt it was important for their transition (O).

During the second year of implementation, the intervention lead (Director of Education) at AH was fully engaged with the recommendations that arose from cohort 1 findings (as evidenced by the developments made to POD2). In particular, buddying was implemented with more commitment and structure. However, due to practicalities discussed in Chapter 7 (see also section 8.3.1.6), buddying was still not implemented until a few weeks after it was intended:

> *We don't often know in advance who's coming, or at least we don't know very a lot far in advance. So if you tried to 'buddy' someone with someone, we as an individual department would struggle, because we wouldn't know who was coming and whether they would be suitable or not. I think it's a good idea. It would be how to organise it, that would be the issue. [Supervisor_OMG18_POD2_INT2]*

The intervention lead noted that they could only implement those aspects that were 'realistic' and could only do so much due to the practical implications, although recognised that this may not be the ideal (C). This impacted upon engagement (M):

> *If I had [buddy] the very first time, then I would have used my 'buddy' more. Because I would not have much of an idea, but I am already used to the hospital working…[OMG14_POD2]*

The overall momentum and enthusiasm from the POD planning team continued during cohort 2, with meetings being scheduled regularly for all of those involved in the intervention (C). This commitment was crucial in ensuring OMGs attended (M) and POD's overall success (O):

> *I think the difficulty is locating the doctors, getting them in a room at one point, because unless you've got a committed person in a Trust who has maybe been an IMG themselves or an EEA doctor and has got a commitment and knows the difficulties, then it can be hard. [Expert 1]*
>
> *The local stuff is key. But it will require somebody to put some elbow grease in to write the programme, making sure it happens, making sure it's delivered, doing it every six months, monitoring it and all that kind of stuff. [Expert 2]*

Regional and national level support:

The intervention lead at AH recognised the limitations of implementation solely at the local level. They were keen to involve regulatory bodies, such as the GMC, who could hopefully invest in implementation across the UK. Training sessions alone are likely to be a short-term fix (as discussed throughout), not necessarily solving transitional issues (O) if OMGs are not getting ongoing support outside of the intervention (C):

> *…they love the fact that the GMC offer the programme and they go and have an amazing experience…And then they're on their own! [Expert1]*
>
> *Our system is supposed to be delivering individualised training, but hardly ever will an education supervisor take into account a trainee's IMG-ness, you know, in deciding where we go from here, what are your learning needs…you haven't really taken into full account all the factors that are impinging on their learning path. [Expert 5]*

Support from the GMC, and from the regional level, could ensure that the necessary contextual factors are highlighted and that interventions are implemented most effectively. This idea was supported by the GMC, who recognised the impact on patient safety (O):

> *So I think it needs developing and it's whether the Trusts - which I don't think they have - have got the ability to do that. The regulator is in an ideal position to do that,*

because it's all about patient safety, which is our job, it's all about preventing them coming to fitness to practice, which is our job. Therefore, it's sort of immoral to in some ways highlight all these things and say, you know, you should do this and then not follow them up afterwards. Regulators could say that each Trust has to have, just at least a basic. What will happen in the future? - us linking in then with the Trusts that they're going to. [Expert 1]

Key enthusiasts at the GMC may also help with sustainability of interventions (C):

I feel really passionately about it [interventions for OMGs], it's my thing to drive it forward and to make sure it keeps happening. I feel ill listening to some of the stories and thinking, my God, these poor people…[Expert1]

Despite some enthusiasts and leaders striving for change at local levels, they felt that there was not yet a regional change in attitude towards training of OMGs:

Unless you've got clear, strong, clinical leadership and engagement in something like this, it doesn't happen. Until it's engrained into automatic, it always needs someone to push. HEENE could take a lead role in suggesting, but again they can't mandate – there are few people who can mandate things. GMC's one of them, but they're very unlikely to ever do something like this. They can suggest and it would, you know, it's good HR practice, but unless you've got someone who can nag you, it doesn't happen. [Expert 2]

So right now I think the problem is that it's not in the consciousness of the educators…so the average school or average postgraduate dean may not even know how many even know how many IMGs they have… [Expert5]

Standardisation was also lacking (C):

The level or degree that each Trust do, for example the release for training or put on nights the first week, they need a set of standards. [Expert6]

I have seen so many examples where all that they get is a link to good medical practice, and then you expect that somebody who has just flown in from Ethiopia or India will start working along with good medical practice on day one. I think they need to put in some effort in making sure that we have, you've supported them. [Expert 5]

The GMC, along with other 'experts', highlighted the need for ownership of delivery and understanding of OMG needs:

It didn't work. I think that was due to people's knowledge and understanding of the importance of doing this. It's probably not identified as anybody's priority to do this. You know, that's maybe lack of ownership of the problem…it's not clear in the usual Trust structures whose role this would be. And if you've got a weak medical staffing department spread a bit thinly, they're not going to spot it. [Expert 2]

Without such, OMGs are likely to be dissatisfied (M) and struggle with their transition (O).

As highlighted in chapter 7, OMGs are more likely to engage with interventions at the local level and be more satisfied with ongoing support (M). Dropout rates for the HEENE and GMC interventions were reported to be high (see Chapter 6), possibly due to the fact that OMGs had to travel to the locations:

> *This is in-house so that's much more attractive to them than having to spend money and go somewhere and do it. OK they might be a certificate there or something like that, CPD points or something. But here this is in-house and that's what they will prefer. [Supervisor_OMG19_POD2]*

However, due to the barriers discussed in barriers (section 8.3.1.6), the GMC felt that implementation at the local level would be difficult:

> *…we had the original idea of Welcome to UK Practice, when we developed it, of doing it in Trusts, exactly what you said, because we recognised that it should be local really, totally agree with you, and that it would be much more sensible to do it like that, but actually trying to get, and I have tried, to get into induction programmes for a Trust; (a) they don't know, when you go to a Trust induction they don't know who the overseas doctors are, because HR, to be fair, can't extract them, it's quite hard. It was almost funny, you'd go to an induction and you'd say, well, could we just pull out all your overseas doctors and do like an extra induction, and they'd say, well, we don't know who they are, so that becomes really difficult. [Expert1]*

This section takes the findings from cohort 1 further, illustrating that support from a higher level may help with the practicality issues identified in this section.

8.3.1.2 Resources and workload

Available resources:

The use of internal educators and regional resources during POD cut the cost of training quite substantially (C). The clinical educators had a great deal of experience in delivering communication sessions and therefore resources were readily available. Lack of resources (C) was noted by the GMC as a reason why a higher level of support and training is not offered nationally to OMGS:

> *It's about what's feasible and at the moment it's a half day. I would personally like to be a full day, but it's about cost, rooms, all the things that you know about. The Gold Standard is definitely a day that we would run, I would definitely believe that and we'd do much more communication stuff in the afternoon, but we just cannot justify that amount of money, and it's a difficult one, isn't it? [Expert1]*

Local level implementation could help to overcome such issues. The use of internal resources at AH meant that POD could be implemented across a number of weeks and that sessions

could be repeated (C). The purpose of this was to increase learning opportunities and attendance (M).

High workload:

Rota issues (C) were still an issue during POD2 that hindered engagement with sessions (M):

> *Yeah, I put him down…but the rota maker does not allow this guy to attend the POD [Supervisor_OMG19_POD2]*

> *They agreed to give me the time off, they agreed to give everything, but ultimately what I attended I attended in my own time. I was doing nights and the next day I was coming to attend the course. I think they need to release the people to attend the course. They even didn't try. [OMG17_POD2]*

Even when individuals attended, many arrived late or had to leave early for meetings and clinical duties. Certain days had been chosen for POD (these best suited the OMGs work schedules), however, one of the days had to be cancelled due to a lack of attendance.

The POD team expressed frustration with this and found it hard work chasing up those who should be attending. OMGs also expressed frustration and stress resulting from their inability to attend POD due to their workload (M). Experts noted the difficulty in taking doctors out of work to attend training:

> *…the difficulty with all the local things is it's done as they're working, so they're already at work. What you'd quite like to do is get them before they start. Once they're in, after their induction day usually, they're full on, so you can't extract them from practice. [Expert1]*

Some Trusts would find getting OMGs out of work more difficult than others:

> *People haven't got very much time and in a Trust that's struggling there aren't many people; there are lots of rota gaps. If you're going to need doctors to do this, that takes them away from the work, which is also a sensitive area…and in a Trust where even putting a picture on a wall has to go through finance…when you're £70m in debt and someone says well we need to spend a few hundred pounds on a new, yeah shove off, basically. So it's financial. [Expert2]*

Because the organisational level was hindered, a lot of emphasis was placed on ongoing support at the training level, particularly from supervisors. However, many felt that increased support was not possible due to high workload (C):

> *I think the example that you give of trainers behaving like that may well be due to the fact that trainers are themselves under pressure and they don't want to know. [Expert5]*

Yet where supervisors at AH were putting in more time, OMGs were sometimes too busy to engage (M):

> *… So what happened was I asked him to come and meet, he then didn't come for some reason, you know, I think he was busy in the ward and then I give him another one that he didn't come for that. Then I had to call him in the Ward. I think there are certain things probably he doesn't appreciate. I think in that way he might need a bit of guidance. [Supervisor_OMG14_POD2]*

As illustrated above, workload hindered knowledge and understanding (M).

Online resources were utilised in some Trusts as they were unable to implement full interventions, for example, following recommendations from Cohort 1, Blossomvale Hospital made use of an online learning programme. HEENE are currently developing a forum for OMGs that will provide guidance and essential information.

The findings here highlight that in all cases, resources and workload negatively impacted on implementation of the intervention, very much supporting the theory developed in cohort 1.

8.3.1.3 Dissemination and information

Lack of information to support initial transition to the NHS (within the organisation):

Chapter 7 illustrated that initial information for OMGs was often lacking. This viewpoint was supported by OMGs that did not attend POD (C):

> *I did my appraisal and my appraiser didn't tell me that I should do my mandatory training. So when they transferred all the information to this Trust, the information that I'm lacking evidence, so they were suggesting deferring my revalidation date, then I found out that oh I should have done these mandatory trainings, that's why they are lacking evidence; nobody told me about the CPDs. [OMG16_NON2]*

Through discussions during POD, some OMGs became aware that they had not taken part in mandatory training that was required for all staff working at AH. Some individuals had been working at the hospital for a few weeks and therefore felt stressed and dissatisfied with the lack of information and guidance they had received (M). A lack of information was evident in all groups data sources.

Lack of dissemination of available information and support at national and regional levels:

Findings from cohort 2 also illustrated that resources were readily available for OMGs new to UK practice, for example advice on renting houses and e-learning resources. However, the information was not utilised by OMGs (M) as they did not know about it (C). Many OMGs

were also unaware about the GMC induction (WtUKP) and other products they offer. This was evident by the fact that the GMC struggled with recruitment. The GMC recognised the logistical and resource challenges in providing information to OMGs:

> *…we've actually reverted to advertising it to doctors who've got their approval for their registration and also doctors who've passed PLAB 2 successfully, because we have, not we have control, but we know who they are, we can send out, we can target them all, send out an email to everybody, therefore it's much easier and also they're not in practice at that point. We're the people who know who's had an approval, who's passed PLAB 2, nobody else is going to know that..so they could be at home and they only come to the UK then probably when they come for their ID check. So it is really difficult doing it locally. [Expert 1]*

This further highlights the need for GMC support when implementing interventions at a local level; they have the necessary information needed to identify OMGs (C). Experts have suggested the need to capture OMGs before they start work, however this difficult at the local level (AH) due to identified barriers (see section 8.3.1.6). Some Trusts have specific online learning modules and handbooks for OMGs, but due to their inability to identify OMGs early enough (C), this information was not always utilised (M).

There is also a need to be sharing findings and best practice (C) to ensure resources are utilised (M):

> *I mean obviously like your programme there are things going on in parts of England. [Expert3]*

As illustrated in section 8.5, an online intervention that was developed in Manchester was utilised by AH, which further helped to increase understanding about UK practice (M).

Dissemination and awareness of POD:

Awareness of POD was higher than was evident in cohort 1, which meant that all staff at AH were more engaging (see section 8.3.1.4):

> *I'm going to get two of the doctors going to that online programme, and then attend the POD as well. That will be in August or so. Because there's so much a time gap I want them to attend the online one as well. [Supervisor_OMG19_POD2]*

However, recruitment for POD was perceived to be too informal by OMGs, emails perhaps not being assertive or explanatory enough (C). Attendance was not mandatory and therefore given their high workload, this informal invite hindered engagement (M). Some OMGs regretted the opportunity to acquire necessary information and receive support:

She talks about the POD quite a lot. She said it was really helpful. And she did say that there were other doctors who wondered why they had not attended. [Supervisor_OMG19_POD2]

OMGs also illustrated that the lack of information concerning the content of POD (C) led to increased feelings of stress and dissatisfaction (M). They felt they should have been made aware of what was expected of them, such as taking part in simulated scenarios. Because they did not entirely understand the purpose of the training (M), they thought the (Objective Structured Clinical Exams (OSCEs) were assessments, and therefore they did not feel prepared to take part:

And then there was a guy who said I won't sit an OSCE. He was feeling like oh I'm not prepared for this, things like that. So communication part of it, this is the programme and this is from day one to day three, these are the three things. And what exactly was meaning by these things…before it starts make it more proper communication. [OMG19_POD2]

Expectations and objectives of POD were explained in the first session, however some OMGs felt there was not enough detail about the specific sessions.

Overall this section highlights that further dissemination of resources; at local, regional and national level, was necessary to ensure OMGs engaged with the information and support available.

8.3.1.4 Organisational culture

Need for a supportive culture:

A key factor that has been reiterated throughout this research project is the need for ongoing support to ensure OMGs make the most efficient transition (O). Interventions will not be as effective if a supportive culture is not in place alongside it (C). At AH, the supportive culture led to satisfaction and opportunities to increase CHC (M):

I must mention that everybody's very helpful. I'm yet to meet a person who's not been helpful. It also helps by the fact that there are a lot of people who are coming from India or Pakistan. There's a strong group kind of thing, you feel comfortable that way. [OMG17_POD2]

As is evident in the above quote, there were a high number of OMGs working at AH (also supported by the performance data presented in section 8.2.2). This was likely to reduce feelings of alienation and increase CHC (M). In discussions with experts and OMGs from other Trusts, where there were a lower number of OMGs working in the hospital, support

was often lacking and many OMGs faced bad experiences (M). This impacted upon performance, retention and patient safety (O):

> *I was given time to adjust here. In my previous post it was a nightmare, so straightaway, a week after I came to the country I did weekend on calls. First year was very, very stressful. If you don't know how to relax, how are you going to express your help to the patient, it's impossible. [OMG13_NON2]*

> *Friendlier than my previous experience in London, you know. Not that they were bad guys there. It's a different climate, different atmosphere. And they're very, very supportive, nobody declines help for us as we're doing, you know, risky procedures and interventions that's very important. [OMG13_NON2]*

Experts emphasised the importance of this supportive culture in OMG transition (O):

> *…it's part of the sell. I think it's part of a good organisation that actively recruiting and looking after the staff that are coming in that they actively support people who they feel may struggle in some way or might take a little bit longer to settle in than the other group. I think just the mark of a nice place to work: not trying to be prejudiced in any way. You would hope that it would automatically happen, but the reality is that if you're coming new into an organisation, you need somebody to help you find your feet, you know, this lot might even need help to find the canteens on your first list of jobs. You're never going to find a 'buddy' on your own. [Expert 2]*

Where such a culture is lacking, regulatory bodies and regional support could help to facilitate this through guidance. However, it is noted as being a difficult task:

> *I think that is a longer term programme, because it really is about changing attitudes like you said, because we can't tell, so what is the formula of dealing with these students, you know. Obviously there isn't one, you know, because not all trainees will be the same. So there isn't a set formula, and we don't want people to be stereotyping other people. So it really is about recognising that you have to take some time in individualising the learning plan for them, and you have to treat an individual like an individual and be curious about them and be supportive towards them. [Expert5]*

This supportive culture at AH meant that Trust and Staff And Specialty (SAS) doctors were given more support than previously (M), as both colleagues and supervisors were more aware of their needs. The Trust Doctor Tutor also facilitated this. Given that there was a fairly high number of doctors in Trust posts (see performance data in section 8.2.2), who were identified in this project as perhaps facing more difficulty in their transition, the extra support may explain why incident rates did not reflect this (see section 8.2.2) (O). As with Chapter 7, findings also support the notion that AH has high success rates of progression (section 8.2.3) (O). The findings from the performance data in section 8.2.2 illustrate that a high majority of

OMGs were in training posts at AH. This progression is likely to be the result of the supportive culture:

> *A lot go on to get training posts. We are supportive in terms of career development. Essentially we treat them the same as those in training posts. [Supervisor2_OMG20_POD2_INT2]*

Local level implementation facilitates the development of a supportive culture:

Local level implementation of POD helped to facilitate the supportive culture. It also illustrated the high level of support available for OMGs at the hospital, increasing their satisfaction and confidence in the organisation (M). POD is now seen as a necessity and has become part of the culture (C). This led to greater successes in all aspects of the intervention and should help to overcome the recruitment issues that have been discussed (illustrated in resources; sections 8.3.1.2, and barriers; 8.3.1.6). Many supervisors and colleagues also identified and referred OMGs who could benefit from POD. This was not only through increased dissemination of findings from both within and outside of the Trust, but OMGs were also feeding back to their supervisors and colleagues about the benefit of attending POD.

As awareness about OMG transition increased within the Trust, extra support for OMGs became the norm (C):

> *So my plan is to put these other two in touch with the Trust Doctor Tutor as well when they arrive so that they have somebody to report to in that sense. [Supervisor_OMG17_POD2_INT2]*

Buddying also began to happen automatically and all levels of support became involved in the process, for example some supervisors had already allocated buddies. More organic relationships were also formed (section 8.3.2.4). This growing positive culture may explain why incident rates dropped by a substantial rate over the course of one year (between cohort 1 and cohort 2 findings).

Need for an open culture:

Rigorous procedures were also in place at AH to monitor performance and ensure patient safety (O):

> *There's a fair patient safety culture. So if there are issues they're very quick to say well who's the supervisor and then email or get in touch or send, you know, so we do know when our trainees have got needs and we need to meet up with them and see how things go. [Supervisor_OMG15_POD2]*

Supervisors from AH discussed their high rate of reporting incidents (C), also illustrated in Table 13. Despite this making them 'look worse' compared to other Trusts, they felt that this was crucial for the CPD of their doctors (O). AH ensure supervisors reflect on all incidents with their trainees, increasing knowledge and understanding (M) (see supervisor support in section 8.3.2.5). Their internal system of collecting rigorous Educational Governance data also illustrates this. Trainees are put into this system whenever they are involved in any incident, even if it was not directly related to them. This ensures they learn from incidents (M). However, supervisors reported that this sometimes led to increased stress (M), particularly for OMGs who are not used to the system or wanting to be seen as making errors. Because all incidents require the filling in of documents, they may also fear that this will be reported to HEENE. In comparison, some Trusts may not have such a high reporting culture or be less willing to report incidents to regulatory bodies. And where they are reported, supervisors may also fail to reflect on incidents with their supervisees (M), hindering CPD and ultimately jeopardising patient safety (O). Because there is no triangulation of data between Trusts, this could potentially cause performance issues when doctors move between Trusts (O). This was illustrated by one OMG from AH who was highlighted as a 'major concern' however had already moved to work in another Trust by the time it was reported to HEENE. The new Trust did not hold details of the incidents.

As evident in this section, the supportive and open culture at AH facilitated OMG transition, possibly explaining why incident rates were lower for OMGs than UK graduates (section 8.2.2). Local level implementation is highlighted as crucial in facilitating this culture.

8.3.1.5 Context of the work environment

High recruitment of OMGs:

Experts placed emphasis on the fact that hospitals that were struggling, were more likely to recruit from overseas:

> *…places more likely to be recruiting overseas doctors are more likely to be those that are struggling in other aspects. I'm saying that as a sweeping statement without any factual evidence, but it's just, I think, a reasonable assumption that central Newcastle hospitals have probably fewer. [Expert2]*

Those Trusts struggling in terms of recruitment, and ultimately performance, often had limited resources and high workload. Therefore, the support offered to OMGs was likely to be lower:

> *…suppose it's how busy a post is as well. I mean, we were three doctors and so we could share things among us and I didn't start on-calls for the first month, so I had time to shadow people. And before I had done my first outpatient clinic, I had time to shadow the consultant. So I guess it's down to like the individual Trust actually, you know, this doctor hasn't worked for the NHS before, so he can't just start coming in the hardest or busiest post on the rota, and just let them pass it on because that's not going to happen, or they're going to be really, really stressed. [OMG17_NON2_INT2]*

This led to major concerns as rates of OMGs were growing in some Trusts, but interventions were lacking. Experts were worried about patient safety in such Trusts. Some experts felt that regulatory bodies were not willing to support implementation of interventions and therefore had no choice.

Differing levels of support:

Findings also supported the notion that OMG route to entry or post obtained determined the level of support they received, for example those that were recruited through the MTI scheme were given a vast amount of individualised support (C):

> *…we've had a few on the MTI scheme and they have one-to-one support. We've not put any formal programme in. I see the paperwork that goes through in support of an MTI. You usually have got three or four consultants: one of whom is Nigerian, one of whom has been to Nigeria, the other one's desperate to get there stroke services working, you know, and it's just beautiful. It's individualised. [Expert2]*

For some, the transition was much easier than others (O), particularly if they had not gone through the initial stress (M) of job searching:

> *This is called Overseas Sponsorship Scheme so it's one doctor to another doctor. So it's like a sponsorship scheme. It's a different system, because most of the traditional system is all the doctors from overseas come here. They register for the PLAB exam. They pass the PLAB exam and then they apply for jobs, right. I'm in an A&E kind of setting where I work with the GMC. Say for example we have vacancies in certain sub-specialities and then we can fill those gaps as well. So it's both service as well as educational need. So the GMC has given me the authority to select candidates from overseas…I bring them here for future training. [Supervisor_OMG17_POD2]*

OMGs with a high level of initial support seemed to get a head start in terms of their adjustment. This very much facilitated overall performance. Emphasis was placed on the fact that regulatory bodies do not support OMGs in getting this initial support.

8.3.1.6 Barriers

Barriers created by poor links with HR:

Although the Educational Department at AH had developed better links with HR, the communication was hindered by organisational restructure. It meant that, like during POD1, it was still hard to get information from HR about POD candidates (C). The POD team recognised this as a limitation as recruitment for POD was always short notice; names being identified last minute. Supervisors noted their inability to identify OMGs without the help of HR:

> *HR has the list who is a newcomer, who is the new starter. It's very difficult for me to identify these people. Unless they come and specifically say look, you know, these are the issues for us and we need help. [Supervisor_OMG17_POD2_INT2]*

Barriers created by not having a mandatory intervention:

AH planned to make POD mandatory for foundation doctors and Trust Doctors. Unless mandatory, they would not be able to capture all OMGs (C). They also wanted to mandate it for those who had faced performance issues. This was for the benefit of patient safety (O). They also hoped that regional support could help to mandate such interventions, or at least improve recruitment by providing information about when OMGs have been appointed. HEENE hoped to set these standards in the future. It was felt that Trusts should not be afraid to highlight concerns with OMGs. Some individuals from the GMC raised concerns about making interventions mandatory for OMGs, however others noted the importance of this, particularly for those doctors deemed at risk, such as locums:

> *Locums are an at risk group and that's certainly an area, and you see the trouble is the Trust, if they appoint a locum you could argue that it could be mandatory for that locum to have been on an induction to UK practice, that could be another good recommendation that you have, that that's a mandatory thing rather than - it's almost like doing your basic life support training, do you know what I mean, being mandatory that you know about the UK health system. Locum agencies are a real worry for me personally and certainly something that I think we're going to have to target fairly soon. [Expert 1]*

Barriers created by a lack of sufficient monitoring of OMGs:

As illustrated in Chapter 5, it was also extremely difficult to monitor OMGs once they began working at AH, particularly those in non-training posts or those that came into quite senior roles (C). This hindered necessary learning and support (M):

> *I was missed between the cracks, that was the only thing, because here they do it during their F1, F2, but I skipped that part, I never did that. But I was as an ST1 here,*

so technically I should have done them but I never did. I was told I should have done it. I can't really get what are the things that I should have done if nobody told me that I should do them. [OMG18_POD2]

They're tucked away in a corner and really, nobody, apart from the people that they work with day-to-day, know of their existence. [Supervisor_OMG19_POD2_INT2]

Some staff members were not known to the Educational Department and they did not appear on any staff lists, which highlights concerns about how OMGs are regulated in each hospital (O). The development of a Trust Doctor database (instigated by the Trust Doctor Tutor and supported as much as possible by the HR department) helped to overcome such issues at AH (C). The database was updated on a monthly-basis, making it much more robust than other attempts, and ensured this group of doctors were monitored and offered ongoing support by the Trust Doctor Tutor (M):

The other problem I've had is I've not been able to make out who's a Trust Doctor and who's not, because no one knows. The finance, the payroll department doesn't know, human resources don't know, so some of them just get missed out for months together, sometimes years together and no one knows that there's a Trust Doctor that exists who's doing the print-off. So now I've amalgamated all the data that we have from all the different departments, and hopefully that's going to be more robust. [Supervisor_OMG19_POD2]

The difficulty in identifying Trust Doctors is particularly important as they are viewed as a group most at risk of facing difficulties (O):

That's the other problem with the Trust Doctors, they're completely for service commitment; they have no training element as such. So they're not protected from a training point of view. [Supervisor_OMG19_POD2]

This one individual was appointed in September, but due to visa issues, they didn't start until May. It's really difficult. And then, you know, everybody else is already in their roles. They will need that extra support as well to get up to speed. [Supervisor2_OMG20_POD2_INT2]

Discussions with HEENE highlighted that a high number of OMGs that take Trust Doctor posts do so because they are unable to get onto a training programme. Trusts are therefore left with the paradox that patient services are being delivered by the very doctors who were judged as not having the competencies to fill those posts as part of a training scheme (HEENE). One supervisor at AH discussed how one Trust Doctor from overseas had been appointed at the wrong level, and as a result had to leave (O). This was partly because they did not have the correct level of support (C). Issues were not flagged up until patient safety issues arose (O):

They don't even know how many IMGs they have. They don't know what the IMGs' pass rates are. You know, none of this exists in their consciousness, and I'm really trying to change that. [Expert5]

The role of the Trust Doctor Tutor was to monitor these doctors to ensure they have the necessary resources and do not get into such difficulty (M). However, this was not an easy process:

…They wanted me to set up an ARCP [Annual Review of Competence Progression} process for these Trust Doctors. But before I can give them goals and try to feed them back many of them have moved on. So it becomes frustrating then as to how I catch them, because they would have moved on already. [Supervisor_OMG19_POD2]

The fact that job descriptions are kept vague, in order to increase the number of applicants received, does not help the situation (C). Some OMGs felt that they could not fulfil the expectation of the role (M):

So the job description is different from what I did there and the skillsets that I need are different…they've been expecting me to know what a trainee from this country would know, basically to decide or make clinical decisions. So it's been very difficult. [OMG15_NON2_INT2]

Such issues are the responsibility of both the organisation and the individual to pick up on (individual factors discussed in section 8.3.3).

As discussed in section 8.3.1.3 on dissemination and information, it was thought that the GMC could also play a role in improving how all OMGs are monitored by providing information to organisations about OMG status upon arrival. However, the GMC were reluctant to do this as they did not want to create a sense of stigma. Many experts seemed to view the identification of OMGs as a positive, rather than a negative. OMGs themselves were receptive to the idea of extra support. It was thought that because OMGs are likely to face some difficulty in their transition, it is merely a preventative measure (O):

…they're probably trying to be uber-employer, fair and equal to everybody, but you're not trying to advantage one group. You're just trying to make sure they're not handicapped in some way by process, giving everyone a fair chance. Sometimes means helping some people so that everybody gets that same footstep. And, you know, we have our prejudice or our assumptions about overseas graduates, maybe the GMC aren't giving us enough information. [Expert2]

As illustrated here, there are a number of identified barriers that have hindered the success of the interventions. Greater emphasis is placed on the lack of monitoring of OMGs and poor links with HR.

8.3.1.7 Summary of organisational factors

The findings illustrate that the supportive and open culture at AH facilitated OMG transition. Ongoing support was established as the cultural norm within the hospital. POD also targeted OMG training needs, providing both skills training and support systems. Availability of resources and workload determined the amount of support that could be offered and whether OMGs could engage. Regional and national support could help to facilitate successful implementation at the local level, overcome the identified barriers that organisations may face and ensure sustainability.

8.3.2 Training context

Figure 23 illustrates the refined training contextual factors developed from both years of data collection. Each are discussed in turn in relation to cohort 2 findings.

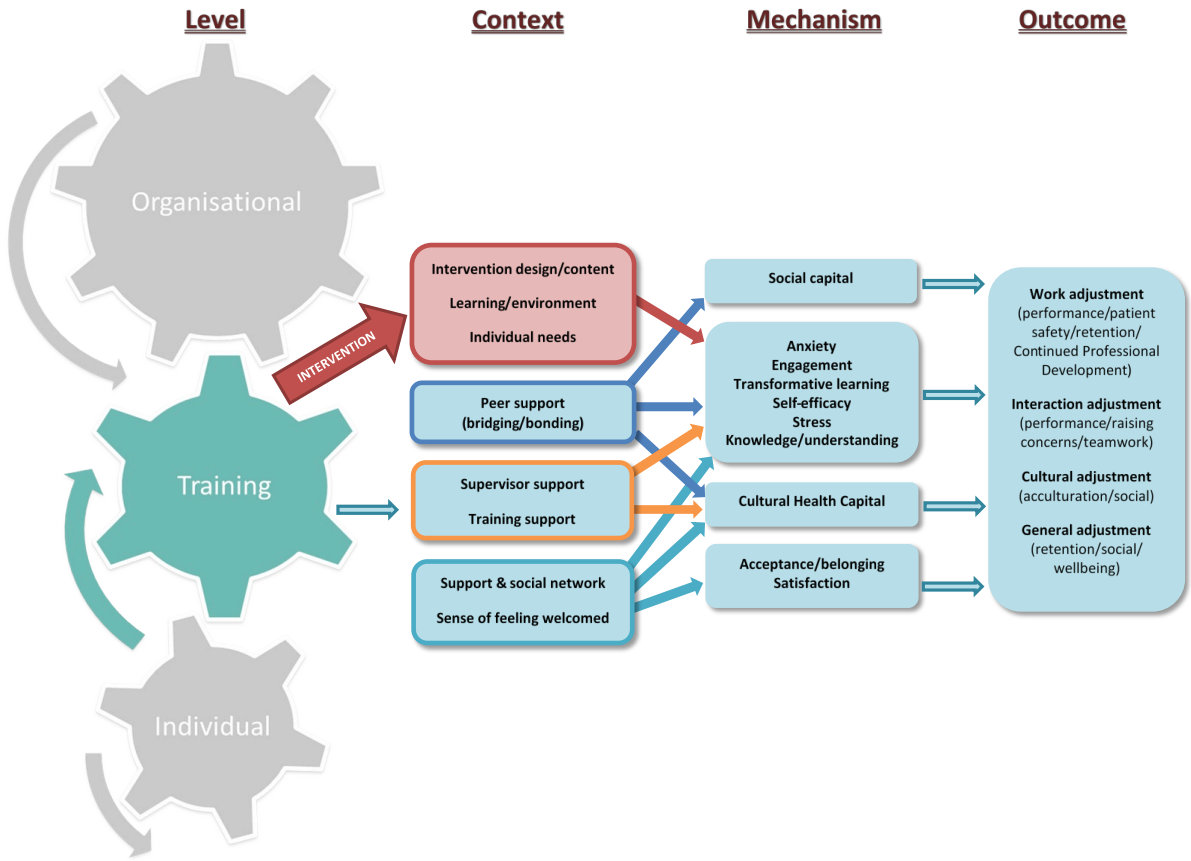


Figure 23. Refined programme theory; training level

8.3.2.1 Intervention - Design and content

The findings from cohort 2 emphasised the importance of the POD sessions (C) in increasing self-efficacy (supported by questionnaire data) and reducing anxiety (M):

> *She's a bit more confident now. She's more comfortable now. Initially she had lots of anxiety and because she was new to the system she had lots of her own fears. I think she's now settled in nicely. She's more confident. She does, she gets involved in the clinical decision making process in an active manner now, so things are improving. [Supervisor_OMG16_POD2]*

Following POD, particularly assertiveness training, OMGs felt more able to ask questions in practice (M), which ultimately impacted on performance (O):

> *Now I have a habit of asking people, asking help, asking advice. So usually I didn't have the confidence to ask, I felt a little bit shy about it. But now I don't feel like, I'm*

used to it now, I just go and ask anyone, just ask little things. So I think I'm all right now. [OMG14_POD2]

Yes, definitely the clinical thing has improved and the knowledge has improved. Initially when he came in he was a little bit reserved, what shall I say? Like a bit apprehensive of speaking out at times, but he does speak out now. [Supervisor_OMG14_POD2]

Career progression was also noted (O).

POD also increased understanding about the culture of UK practice and communication (M), 'bridging' a gap that led to transformative learning (M) and better adjustment (O) (supported by questionnaire data):

So with this course it's just like a bridge or something like that…it gives a little bit of knowledge about what we expect in the work, and what we expect within the environment and everything else. I was expecting those kind of accents from the patients as well, I will be more aware of that. I mean after this course. I just want you make my job easier to approach from the, either from the colleagues, either from the patients. [OMG14_POD2]

That was really helpful, because working in this environment, communication is very key, and it covers so many different types of communication, how we improve, how we communicate effectively with the patients, your colleagues and in your day-to-day practice…end of the day providing the best quality care with improving the communication - that was really nice...[OMG14_POD2]

POD2 included sessions ran by the GMC, which proved to be extremely important in terms of providing resources and increasing understanding about UK practice, policies, processes, and pathways (M):

I think that is something that was one of the highlights of the programme, the lady from GMC who came for a little talk. I think that was really good. Yeah, because when we do our registration with GMC the sort of paperwork that we are doing and so many things we are just saying yeah, okay yes we agree, without understanding the importance of it, you know what I mean. So it's important to have a refresh and also know what GMC want you to do. [OMG17_POD2]

Many OMGs from AH were unaware that they needed insurance until POD. The GMC further reiterated the need to disclose error and how to manage difficult situations (M).

OSCE stations were also added to POD2, covering practical issues such as cannulation and blood cultures, as they were identified to be problematic for OMGs in POD1. This training was important in assessing needs and signposting to further training (M).

Issues with implementing POD1 too late were noted in Chapter 7. However, the timing of POD2 training seemed to suit most of the OMGs, who stated that transformative learning was most likely to occur if they could bring experiences with them into the training (M):

> *I wouldn't want to take it earlier. I really don't think it should be taken before you start work. Why it was so beneficial for me was because I could relate to almost everything. I could judge myself, I'd be like OK, I should not have done this here, I should have done this here, it should have been a more polite approach, my tone of voice was not nice here, it was good here, and it's kind of set a balance for me now. [OMG16_POD2]*

The importance of follow up sessions was noted by the POD planning team and the GMC; to draw further on experiences and reflect on practice (M). However, practicalities, discussed at the organisational level, hindered this at AH (C):

> *…the ultimate aim, wouldn't it be lovely if we could then invite all those people we - I think we will in the future, to be fair - the people who've been on the GMC day, invite them back six months later to come and do another half GMC day to pick up other issues, do you know what I mean? [Expert1]*

This section reiterates the importance of POD content and design, which was evidently more successful following recommendations made from the POD1 evaluation.

8.3.2.2 Intervention - Learning and the environment

Despite being beneficial, some OMGs were resistant to the OCSE-style scenarios that were added. Some OMGs had not done OSCEs before (C). This difference in teaching techniques led to anxiety for some as they did not want to appear 'stupid' (M). Some also viewed the practice as an examination and stated that had they known what the sessions involved, they would not have wanted to attend (M):

> *I think it should again be training orientated more than examination orientated - because obviously people who undergo the OSCE have had some previous training of some similar situations. Some of us, I mean especially if somebody was coming from India, we don't have OSCEs in India back home, this is a foreign world. I came in from a little better background and I came in from US, India, US and UK. So I was a little better adapted, I mean I could have, I would have dealt with it a little better than say somebody who have just directly come from India. There's a good chance he wouldn't have known what to do exactly. [OMG17_POD2]*

Cultural differences also played a role in learning (linked to section 8.3.3.2):

> *Some of them are confused because the way we do things, it's all exam oriented in India, so you read lots and lots of books and you have to pass an exam, whereas here the way they are supervised is more clinical work and the exams are not so important,*

except at some stage in their career. So there is a little bit of difference and for us from the Asian continent. [Supervisor_OMG20_POD2]

However, the overall environment of POD seemed to reduce general anxiety and increase self-efficacy (M). It allowed questions to arise in a safe environment (C), which further engaged the group (M):

I was very open, I was telling all the silly things that I did, and what people thought about it, I didn't hide anything, I was very open. I said OK these are the things that happened to me. [OMG19_POD2]

…it did boost my confidence in a way where I felt a little better when I saw a lot many guys in my similar situation, so that was definitely a big plus point of the programme. I mean that kind of got my nerves down, I felt better at that stage. That was definitely one of the big points. [OMG14_POD2].

The value of sharing and learning from each other was evident (M), which was thought to facilitate transfer of knowledge into practice (O).

Role-modelling was more evident during POD2 (C). Story-telling from a senior OMG facilitated learning and helped to reduce anxiety (M). The senior OMG was present throughout most sessions and helped OMGs to further understand the system and career progression (M). Not only did he add a sense of humour to discussions, but added a realistic and insightful perspective about what was to be expected in their transition. Discussing his experiences and offering advice helped to increase self-efficacy (M), which was particularly important for those facing initial difficulties.

Although some experiential learning was evident, fewer role-plays were included compared to the previous year (C). The communication sessions ran by the HEENE trainer were highly interactive, but did not involve any role-plays. They instead targeted self-reflection and self-awareness of communication in practice (M) (which was highly useful and appreciated by OMGs). The POD planning team recognised this was due to a lack of direction on their behalf. The sessions ran by educators from AH were also largely didactic, apart from the specific role-plays with simulated patients (*Hard days night*). Experiential learning (C) was deemed important for transformative learning (M):

You can learn only by practising, only by seeing others and things like that. The others are, you can bleed the staff and try making sense of it, and try improving on that. But communication is one thing that if you can't do that you just need practice, and it's inbuilt in the UK medical school curriculum. But that's not the case with the overseas doctors. [Supervisor_OMG19_POD2]

However, the educators, being UK graduate nurses and doctors, did add a valuable perspective during discussions that enhanced knowledge, understanding and reflection (M):

> *…another good thing is like you are all sitting from overseas, everybody sharing their experience, and then difficulties and their own expectations, and then somebody from UK trying to explain the basic differences and then how the things work here. [OMG14_POD2]*

This section reiterates the need to take OMG learning preferences into consideration and highlights the importance of experiential learning, role-modelling and the sharing of experiences within a safe environment.

8.3.2.3 Intervention - Individual needs

Questionnaire data highlighted that all attendees of POD2 felt the content was relevant to their needs, regardless of their level or post. In comparison to POD1, there were fewer foundation doctors that attended. This illustrates the importance of offering POD to all OMGs new to UK practice, not just a specific group:

> *…we did think about rebranding it for foundation doctors, but actually, we thought that foundation doctors have an awful lot of induction, training, support, and actually they're not the people that are at risk…better induction than a doctor who just literally walks from an ID check into a job at - sort of the Trust Doctor. So, first we were trying to work out where the risk was…it definitely is just the IMGs who are just going into post in Trusts really. [Expert1]*

The POD planning team wanted to offer the intervention to any OMG that would benefit, however, the focus was on those new to practicing in the NHS. OMGs did not necessarily need to engage in all aspects of POD:

> *…knowing the Western system to some degree, he may be quicker to adjust. But somebody who's coming very raw from say India or Egypt or somewhere else, they may struggle. So they may be better off having all. [Supervisor_OMG17_POD2]*

POD2 included an initial needs assessment to deem the level of support required. Findings from POD2 supported the programme theory from cohort 1 that OMG needs reflected individual differences (see section 8.3.3.2).

8.3.2.4 Peer support

Importance of being able to relate to those from the same (or similar) culture:

All OMGs during POD2 data collection expressed the need for their 'buddies' to be from a similar culture (C):

I tried to find Pakistani people around in the hospital and then go to them, and then they look after. And then they are also, they feel it's their responsibility to help. And like Indians go to Indians…the people who come from the same area, they know how to explain, they know what are the basic problems that people have when coming from these areas. So they hit the main target, they don't like talk more rubbish…about what they are expecting. [OMG19_POD2]

Unlike those from POD1, they did not see the advantage of a UK graduate 'buddy':

…a doctor from here would have no idea about all that. [OMG14_NON2_INT2]

'Buddies' from similar cultures noted the importance of their support in offering an extra 'support net' and increasing Cultural Health Capital (M), resulting in better cultural, work and general adjustment (O).

…he was pretty anxious about it. So I'm trying to help him as much as I can. I've been helping him with all the sim cards, accommodations and everything. It makes it all a lot easier because you don't want to, you know, struggle, where do you find these things cheaper, if you want a decent shirt you have to go there; if you want a decent meal that's the place where you want to go…there are a lot of guidelines which I was following and different system works differently. So I'm helping him with the NICE guidelines, NHS, how NHS works, how do they offer a patient, how to operate safely and how to be safe in the ward and all those things. So he's settling down well, in fact he'll move onto a registrar post within a couple of weeks. [Buddy_OMG17_POD2]

Experts supported this:

*…the other thing is doctors who are IMGs themselves in the trusts would be perfect. Thought should be given to this mentor and it would be really good to have somebody else who is also from overseas...*not many of them are doing the mentoring thing. That's where you're unique for your results. I think that's one of your key recommendations really, isn't it? *[Expert1]*

Chapter 7 illustrated mixed preference for having a UK or non-UK 'buddy'. This highlights the importance of taking individual needs into consideration (section 8.3.2.3).

The 'speed dating session' implemented at the beginning of POD seemed to be more successful with OMG 'buddies', in comparison to UK 'buddies'. The session resulted in a type of peer support group and networking (C), rather than a formal meeting like in POD1. This increased engagement (M). The buddying checklist that was developed to aid 'buddies' was not utilised by OMGs as they felt they knew what issues were likely to arise. OMGs were easily matched, some having already met on wards or in their accommodation beforehand:

I have seen him again and sort of developed a relationship with him, only one guy, that's it, and the reason behind that he wanted to do orthopaedics, so there was a common thing between us. [OMG15_POD2_INT2]

Where OMGs were unable to attend the 'speed dating' session, it was important to engage with supervisors to determine who could support OMGs best on the ward. These OMGs also noted the importance of organic relationships developing with other OMGs (C):

I had certainly no support apart from a new friend that I made here just by chance. I mean it was just my luck that I bumped into him, and then he helped me through my initial phase. There was no real support as such, so this one person I could go to. He works in the department and he lives in the same doctors' accommodation. That's how I met him. He's overseas but he's been here for I think three years now. So he obviously knows how things work here, so that was quite helpful. He knew what the challenges were of an overseas doctor coming to UK, so he knew that as well, so I think that helped too. [OMG17_POD2]

This was particularly important where peer support was lacking on the ward, having the potential to hinder Cultural Health Capital and self-efficacy, whilst increasing stress levels (M):

…he made me cry…he thought that I didn't know anything, and I was coming from the jungles of Africa. [OMG15_POD2]

…the reg at some point started asking "Oh, do you want me to do your job for you?" And, "Where did you train?" And, "Did you have ECG training where you trained?" Which was completely uncalled for, especially from another colleague. I mean, a patient, yeah, you know, it's fine, whatever. But it's completely inappropriate to have that from another colleague, to be honest…it sort of shatters your hopes really if you get that sort of treatment. [OMG17_NON2_INT2]

OMGs also noted the impact this could have on patient care (O):

…they tend to kind of tell you sort of in quite a, I feel personally, a very rude way that they don't agree with you and you should, you know, do whatever you like and not bother me…it makes it more difficult because I'm finding it anyway difficult to sort of communicate with them and to understand what my patients' needs are. And to add to that if you feel that somebody's quite rude to you, then, obviously, you don't want to talk to them. It does affect, I think, the patient as well. [OMG15_NON2_INT2]

Role of the Trust Doctor Tutor:

The Trust Doctor Tutor helped to overcome some of the issues discussed above. The tutor was responsible for ensuring all Trust Doctors were supported, again this benefitting Cultural Health Capital (M) as he was an OMG himself:

> *Probably it's easier for me [Trust Doctor Tutor] to tell them all that because several years ago I was in their stage. And then it's difficult to get that support, they don't know who to, at least I didn't know who to go to ask all these questions that now I've been able to answer for them…he should come to me straightaway rather than waiting for things. There is a neurology specialist nurse who supports him so I've spoken to her as well in case…[Supervisor_OMG19_POD2]*

> *Such a huge support to me personally, always has an encouraging word. When he [Trust Doctor Tutor] knew I had an interest in public health he quickly got me appointment with the clinical director of public health on a face-to-face basis. Anything he tells me, he tries to assist you along the way…he's always encouraging you to ask questions. So he's been so supportive. They don't support on the medicine department. He will always stop and chat, what are you doing, what are your plans, hope you're not going to be a Trust Doctor forever, so which consultant, are you working towards it? I think he's very actively interested in you as a person. [OMG16_POD2]*

Because Trust Doctors only have clinical supervisors, the role of the Trust Doctor Tutor was also to address their educational needs, for example advise on CPD, revalidation and career progression:

> *I think they get so involved in their work there's no one to actually check about their career. Because that's what I keep on asking them, what career progression, how are you going to progress, what have you decided? So I will tell them realistically that OK this many years you'll have to invest, are you prepared to do that? If so that's fine, I can tell you what you need to do. If you're not prepared to invest then these are the other specialties that might be good for you. [Supervisor_OMG19_POD2]*

Peer support was evidently important in successful adjustments, both work and culturally. Those at AH had the benefit of having the opportunity to engage with a 'buddy' and Trust Doctor Tutor. One OMG noted that they were going to leave the Trust, however the offer of support from the Tutor led to them staying.

8.3.2.5 Supervisor support

Support for OMGs:

The majority of OMGs from AH stated throughout this project that they were satisfied with the level of support that they received from their supervisors (C). This was enhanced further through awareness of POD within the Trust (section 8.3.1.4; culture). Most supervisors

recognised the need to support OMGs adequately to ensure performance, career progression and retention (O):

> *…we need to encourage them and support them. When she came originally she was allocated to our ward and she was really struggling. Initially I thought she hasn't got the clinical skills as well. So we worked very closely with her. First couple of months we were concerned that she might not be able to cope, but she progressed slowly, but obviously we needed to – they really need a supervisor who can properly support them, because I've seen people actually breaking down and leaving the whole thing…time should be given to these people and the supervisor as well…you need to meet them frequently on their progress and you have to supervise them very closely. So she slowly progressed and then after four months she was at a level of F2, which was quite pleasing to see. Initially I was asking them can they send somebody else, so it was a bit of a struggle…she has secured a post for GP VTS training. [Supervisor_OMG16_POD2_INT2]*

Some supervisors, particularly those who were OMGs themselves, tended to go above and beyond the level of support that was expected of them (illustrated in Chapter 7). Some supervisors also helped to facilitate awareness and expectations of other staff (see section 8.3.3.4).

Support for supervisors:

In order to recognise and promote this good practice, the POD planning team wanted to give 'enhanced status' to supervisors that behaved in such a way. This meant the Education Department would allocate OMGs to these supervisors. It was evident that these supervisors were driven by internal motivators and not external gratification. Enhanced supervision training was therefore planned for these supervisors, hoping this would facilitate OMG transition further at AH (O). However, the POD planning team faced resistance from some of the supervisors as they misunderstood the meaning of 'enhanced status'. Many assumed it meant higher workload and increased 'burden', and therefore did not appreciate being chosen for the title without their consent. Many even stated that a specific job role is needed for it, as a lot of time can be redirected from patient care for the cause (which is why the Trust Doctor Tutor is there) (C). Experts supported this view that OMGs would benefit from the extra level of support:

> *They could identify one person, like you say, in each Trust that's got the oversight for international medical graduates, EEA doctors. That would be quite nice, a named doctor really. And there could be, one of the high standards could be that there would be a mentoring scheme, some sort of extra clinical supervision that these doctors have like Action Learning Sets. [Expert1]*

It was explained to supervisors that the purpose of the enhanced supervision training was to ensure OMGs were supported by those who have previously illustrated good practice in supporting OMG transition; something that they were already doing it. The POD planning team felt that ensuring the best possible support for OMGs was crucial for patient safety (O). Understandably, not all OMGs could not be supervised by a select few, as that would have created too much of a burden considering the extra time that supervisors would have to commit to their increased number of OMGs. Ultimately, incorporating the enhanced training into the regular supervision training at AH proved to be most beneficial: all supervisors got the enhanced training and individuals were not singled out.

A checklist was also given to supervisors to ensure they were aware of OMG needs and would cover certain topics in supervisions (M). This was implemented following findings from POD1, which illustrated a variance in support offered to OMGs. Experts agreed that training for supervisors was essential:

> *…part of the reason they don't want to know is because they don't know what to deal with the problems. You know, in a way they know what the trainee needs, but then, because they don't have solutions…the trainer feels well what do I do, you know, how do I handle this? And so they just retreat. [Expert5]*

It was also recognised that supervisors should be more involved in POD (C) (see section 8.3.1.1 on intervention development and leadership), for example, it would be useful to link the OSCE needs assessments into their training to ensure identified needs are met. Supervisors could then evaluate and feedback on issues explored in POD (M):

> *I think that there should be some information given to the supervisors as well as to what you're looking to test really; what you want to see. [Supervisor_OMG17_POD2]*

In contrast to the majority at AH, those from CH felt that adequate supervision was lacking to support their adjustment (O):

> *I knew that I should have one [supervisor], I was seeing that there are lots of trainees in James Cook, right, compared to here you see more trainees. I was trying to get supervision for myself and couldn't and nobody was really helping. I was just talking to that supervisor whenever I was finding him in the changing room in theatre and he was going home. So it was very limited time. [OMG16_NON2]*

The findings suggest that support from supervisors, along with support for supervisors from the organisation, would be the best approach to support OMG transition. This therefore adds to the findings from cohort 1, more emphasis placed on the need to train supervisors.

8.3.2.6 Training support

As is evident from the above sections, interventions will be most effective if OMGs are offered support back in the workplace (C). The variety of support networks at AH was thought to increase OMG confidence (self-efficacy) (M), which led to improved performance and retention (O) (evidenced in section 8.2.2 and 8.2.3):

> *I think she had all those things. She had an induction. She had an overseas programme developed in that. I think she's been really fortunate to work with good colleagues. They supported her initially and we are, so the consultant colleagues are very helpful, so she kind of improved. [Supervisor_OMG16_POD2]*

Where interventions were not attended, but support was in place on the ward (C), adjustment was still likely to take place (O):

> *A&E department I think is probably the best place to get integrated because we work so closely together. We're not as hierarchical as the wards are where, you know, you're left on your own to do things for a period of time; there's always your colleagues around you here all the time. So if you have any questions about anything that you don't understand because you don't know the system, it's a very easy place to pick stuff up. [Supervisor_OMG18_POD2]*

> *…just having time and just having people to turn to…just having understanding colleagues really that, you know, understand that you're not stupid; you're just not used to how things are done. And I think I was lucky to meet people that were sort of like this…I learned loads. [OMG17_NON2_INT2]*

However, had POD been attended, leading to increased understanding and confidence sooner (M), the transition experienced by the OMG would have been more efficient (O):

> *You progress, you get to know things, but it takes two or three months or six months to be comfortable actually in a certain hospital, yeah. There was nothing really in place for us. [OMG13_NON2]*

As expected, OMGs in Trust Doctor posts typically felt less supported. However, as discussed in Chapter 7, AH offered training support for Trust Doctors, similar to those in full training posts (C):

> *I think, as a Trust post, I found it quite supportive…generally, whatever they've done for trainees, they've done for us…treated me like a trainee in the sense that I have access to everything that the trainees have. [OMG17_NON2_INT2]*

This training support led to increased Cultural Health Capital and increased self-efficacy (M), resulting in better performance and retention of these doctors (O) (supported by outcome data in sections 8.2.2 and 8.2.3).

8.3.2.7 Support and social network

Social network developed through POD:

Although the POD planning team had initially wanted to implement follow-up sessions for POD attendees, it was felt that so long as a support network had been established (including peer, supervisor and training support), there was no urgency for these sessions. Following the findings from POD1 and POD2, the team were aware that successful transition (O) was dependent on much more than a simple training intervention. POD attendees highly valued the support and social component of the intervention:

> *If we have more frequent gatherings like that it would be nice to have, it would be an added bonus. [OMG17_POD2]*

Given a lack of resources and high workload, it was important to take this into account.

The social night that was implemented during POD (including 'buddies', educators and any staff involved in POD) was viewed as a highlight of the training, partly due to the humour and lively atmosphere resulting from a large group. All OMGs appreciated the opportunity to socialise outside of the work environment in an informal setting (C). OMGs reported that this made them feel even more part of a group and had more confidence following the evening (M). Those who were quieter during the POD sessions seemed to interact more during the social evening and engaged in discussing common difficulties and successes. This opportunity to bond also led to the swapping of phone numbers and arrangement of further meetings outside of work.

Experts agreed that support outside of the work environment is important (C):

> *I actually agree with you, one of the things that we do is encourage them to swap phone numbers, to write a list of people, to set up a WhatsApp group, etc. etc. So you've got informal networking. [Expert1]*

Ultimately, establishing a strong support network led to feelings of acceptance and OMGs no longer felt alone (M):

> *By providing this course you came to know a few people in the first place, and then they are still my friends. I sometimes see them around in the work, I talk to them. I sometimes go there, I say hi and hello, and we talk, say how are you doing and everything. And I think that's good. [OMG14_POD2]*

This had the benefit of reducing anxiety and stress (M).

Barriers to developing social networks:

Many OMGs felt it was difficult to socialise outside of work. This was also linked to factors discussed at the individual level (section 8.3.3).

> *…you stay more, because you come early to see, observe, to help yourself to learn the system. And you stay late because you want to learn the system…it's very difficult to socialise straightaway, the culture is entirely different…ultimately people coming from back home, they end up doing more locums. They say OK, I don't have any pleasure and activities, so why to stay in accommodation and getting bored, better to go and earn some money. So being in the hospital because hospital is the only place that you feel comfortable, because this is more close to what you were at home. [OMG19_POD2]*

> *… it's just me, my husband and my kids so I don't have childcare support from anybody - so that limits my ability to go out or to have a social life. It does not help the fact that I don't drink for any reason, so anything pubs is out of it, which is generally half of the UK. [OMG15_NON2_INT2]*

These barriers highlight issues (discussed in previous chapters) created by the OMGs inability to, or choice not to, create opportunities for bonding social capital. OMGs emphasised in section 8.3.2.4 (peer support) their preference for OMG 'buddies'. Although they can relate to these individuals, OMGs would also likely benefit from bonding social capital (evidenced in Chapter 7).

However, this desire for bonding social capital meant that OMGs actively sought to help other OMGs who were in the same situation that they had once been in (C), increasing their sense of belonging and reducing anxiety (M):

> *I saw a person who was in the same. So I could see he was in the situation, where he came from the US and was working here. The same thing happened to him, like he was here and not working. So then I used to call him, I used to go to him and I used to ask him to come and have lunch together, have dinner together, things like that. So now he's helping somebody. So things are working like this. [OMG19_POD2]*

This section illustrates the need for OMGs to create a support network outside of work, however this can be hindered by a lack of opportunities, their culture and resulting attitude towards UK graduates (this links to the individual level). POD helped to facilitate support networks for OMGs.

8.3.2.8 Sense of feeling welcomed

As discussed in section 8.3.1.1 (intervention development), local level implementation was thought to be most effective when implementing interventions for OMGs. It was particularly important in creating a sense of feeling 'welcomed' (C):

I mean it's very difficult to communicate, to know the people, to know the system, know everything. And as you mentioned, it [POD] should happen within the Trust. [OMG14_POD2]

It [POD] just makes them feel welcome, there's no doubt about that. So I will be sending two more your way. [Supervisor_OMG17_POD2_INT2]

Questionnaire data illustrated that all POD attendees felt valued members of the Trust and were more satisfied (M) following POD. Cultural Health Capital was also likely to increase, OMGs recognising people care about their wellbeing, not merely performance (M):

It's more of a personal approach, people coming forward to help you, not like some admin sort of setup. Because to be very honest, it's a bit harsh but the people here it's like everywhere, the management is more worried about people coming and getting started, and then seeing the patients. If there's anything that can grossly affect your performance, and then you are unable to work, then they will come in and go OK what's happening? But apart from that they are not bothered about what you think and what problems do you have, nobody would give a damn. [OMG19_POD2]

As experts discussed, such interventions lead to feelings of acceptance and belonging (M):

…it's not just inducting them, it's making them feel valued, part of a team, settling them in. [Expert 2]

This feeling of being welcomed will ultimately lead to better work and general adjustment (O).

8.3.2.9 Summary of training factors

Attendance at POD facilitated OMG transition, particularly in terms of their knowledge and understanding. OMGs also felt valued and supported as a result of POD. It was evident that OMGs favoured support from other OMGs, however this may have hindered their opportunities to develop other support and social networks. These networks are important for adapting to the UK; in terms of both the workplace and culture. The importance of training factors outside of the intervention, such as support from peers and supervisors, was evident throughout; facilitating OMG transition further.

8.3.3 Individual context

Figure 24 illustrates the refined individual level of the programme theory. Each contextual factor is discussed in turn in relation to cohort 2 findings.

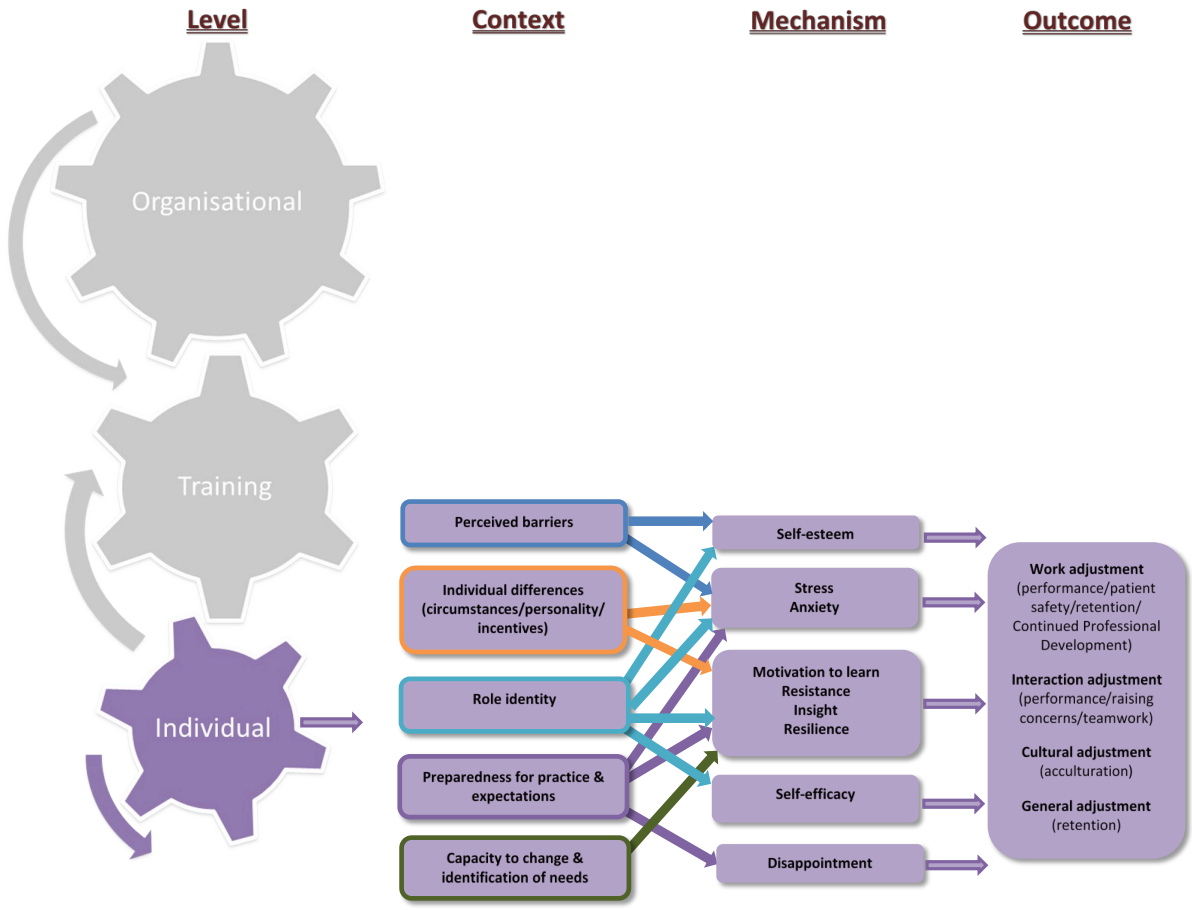


Figure 24. Refined programme theory; individual level

8.3.3.1 Perceived barriers

Supporting findings from Chapter 7, barriers were perceived by OMGs to hinder their transition. The main issues that were discussed included perceived prejudice and discriminatory issues (C), resulting in anxiety and lowering self-esteem (M):

> *I would sort of withdraw and not want to, say, insist on having a conversation with somebody…they sort of pushed me away simply because of the way I talk different. I did find it difficult… [OMG15_NON2_INT2]*

Practical issues associated with gaining a post in the NHS were also discussed (C), leading to increased stress (M) and at times, hindering progression (O):

> *I've told the Trust that if you want to recruit effectively, you sort of have to go out there and make it clear to people, because it just seems daunting when you look at it*

from the outside looking in…it sort of leaves you in a sort of limbo…you can only apply for the sort of posts that you know people have left due to sickness or pregnancy or whatever, and these aren't a lot…I applied literally all over the country from the Isle of Wight to Fort William in Scotland; literally all over the UK - and sort of, of the 70 applications, six replied. [OMG17_NON2_INT2]

I'm applying for a speciality doctor post whenever I get the first one. And then I plan to apply for consultancy in the next, say, four or five years. But yeah, it took a long time. So if all this is told in induction so they have an idea what's going on that can sort of help save all this. I've wasted a year of going around doing all this. [OMG14_NON2_INT2]

The high level of support at AH aimed to resolve such issues; hopefully removing perceptions of barriers from OMGs.

8.3.3.2 Individual differences

The role of personality, incentives and gender:

Personality (C) was again identified as a factor that facilitated transition (O), largely as it impacted upon resilience and motivation (M):

…it still boils down to people openness and personality. And I always remember, my husband always tells me no matter what you do, do not forget who you are. You are actually not from this country…plus I just take everything in my stride, no problem [OMG16_POD2]

There's some very level-headed people, who really just settle in very well. There are other people who I think need a bit more hand holding, and I think that comes down to the individual. [Supervisor_OMG19_POD2_INT2]

Discussions with the GMC highlighted the importance of resilience (M), their findings showing that involvement in investigations of performance led to a higher chance of suicide (O). The communication sessions delivered in POD (HEENE) aimed to increase self-awareness and abilities to manage such difficult situations.

Motivation (M) evidently impacted upon career development and performance (O):

Surgically performance-wise he gradually got into the system…over the last three months showed persistence, interest, keenness, and we've just upgraded him to a registrar level… that's quite fast. I mean the opportunity came and we pushed him. [Supervisor_OMG17_POD2]

…most trainees are wanting to meet, they need something, they're going for an interview or they're wanting some evidence, but he's not had that engagement really. I don't know whether that's cultural in terms of he didn't feel he could ask…but from being quite engaging and polite on the wards there's just not been a particular desire to link in and take things further. Because I suppose I'm used to our UK-based

trainees knowing they need to progress and get things…it's his role as well to get in touch as the trainees normally do. [Supervisor_OMG15_POD2]

It was also evident that OMGs needed incentives (C) to engage with the support that was offered (M). The Trust Doctor Tutor below noted the importance of incentives:

They don't get engaged in that because I guess what they feel is that there's not much to gain by meeting me. And in spite of the three emails, if they don't attend then I do tend to tell them that look it might affect your study leave and things like that, you do need to come and meet me - because I can actually provide them with other study leave arrangements and a few more ideas about how to progress in their career. So most of the times I have been able to meet them at least once a year; some of them trouble me more because those are interested, so they'll come to me quite a few times with help and this help and that help. When there is some difficulty, when they're not progressing, that's when they think OK let me meet this person as well maybe he might be able to help me out. When everything is going on fine, they'll never meet me. There are some who don't want to progress, they're happy with what they're doing so they won't need. [Supervisor_OMG19_POD2]

Where they faced difficulties in their home country, OMGs had more incentives to stay in the UK (C) and therefore built a greater level of resilience to hardship (M):

So what I'm looking at is to get my specialist register and start working as a consultant. I started adjusting to the NHS I also respect the system, in Greece it's quite difficult to find a job at the moment for finance reasons and for other reasons. You know, there is no, you're not equal in Greece with every doctor. It doesn't have to do with the way you've been trained; it has to do with contacts, right…so having some proposals after a year in the NHS it's amazing, they don't know you, but they look at your CV and it's simple as that. I then had to call my wife and say let's look at this long term, you know. While in Greece for example if you're mediocre you will fail. I have seen that if you're mediocre here everybody will support you to make you better…Why, because of patients. That's why I came to prolong my stay here and see what's going on. [OMG13_NON2]

…we look at the United Kingdom as a place where there is more justice, you know, in the selection process, and we want to do better than the locals, you know, because we want to show that we can be better and we want to progress. So many times we swallow a lot of insults, you know, and we try to change our lifestyle completely…[Supervisor_OMG20_POD2]

Gender (C) was also highlighted as factor that could lead to resistance to asking for help (M):

She's very happy to ask questions appropriately. But yeah I think that's right, I think it's probably more the male doctors to be honest; they don't want to appear that they don't know what they're doing. [Supervisor_OMG18_POD2]

The role of family:

Those OMGs who had fewer responsibilities, such as family or children (C), tended to be less resistant to opportunities to progress their career (M):

> *And I think I was quite lucky to be able to get this and I'm aware that some percentage of it was, you know, their need to get doctors. You know, because Scarborough is a bit out of the way, which was fine for me because, as I said, I was alone so I could literally move anywhere. And sort of it gave me that chance to evolve in the past 18 months and do my paper portfolio, do my WPBA, do my communication skills events and everything. I've found, over time, talking to people, like, they're limited in terms of where they can train or where they can go because they've got a family or a mortgage. [OMG17_NON2_INT2]*

However, spouses (C) often helped to reduce stress and anxieties associated with moving to another country (M), meaning focus was on performance (O):

> *When I first came to the UK it didn't take me a long time to settle, because my husband was already here. So I joined him. So I didn't have the accommodation issues or stuff, everything was sorted. So it was mainly me trying to get my head around the exams, which we as international medical graduates have to write before we can practise in the UK. [OMG16_POD2]*
>
> *My husband came here so I came along with him. Yeah, so both of us are here and definitely it makes it easier. If you're alone, it's quite a nightmare. [OMG14_NON2_INT2]*

As is evident from the data in this section, individual differences impacted upon ease of transition. This highlights that individual needs must be taken into consideration when supporting OMGs.

8.3.3.3 Role identity

OMG insight and expectations of the job role:

When applying for posts, OMGs did not always take into consideration the job role (C) and therefore lacked insight in what was expected of them (M) (also discussed in section 8.3.3.4):

> *… I joined a Trust Doctor post without knowing that it was an F2 post because I didn't know what an F2 was in the first place. I was given a job and I just jumped at it and I took it. [OMG14_NON2_INT2]*
>
> *So it takes some time to get used to it, then adjust to a new role. And then you have the communication with those above you and the people who are on the junior course working under your guidance…its hard to manage the things at your level. So these are the bits that we find difficult. [OMG19_POD2]*

Those who were not aware of what the training entailed sometimes started at too high a level and this increased the chance that they would have to return home (O):

I always advise them to decide what level they think they would best fit, and then, drop down one or two levels. Once in core training there is no going back. Once you're out, you're out. Just one chance is all you get. [Supervisor2_OMG20_POD2_INT2]

Staff from AH stated that job advertisements for Trust Doctor posts are often left vague on purpose as Trusts want to ensure they get applicants (discussed in section 8.3.1.6). Therefore, OMGs are sometimes placed roles even if they are not at right level:

Sometimes they're just not up to scratch. But you know, there has to be so many doctors on each ward. [Supervisor2_OMG20_POD2_INT2]

They will big themselves up. They know how competitive it is. [Supervisor2_OMG20_POD2_INT2]

The Trust will then assess the level they are working at once in the post. It was recognised that performance can only be assessed to a certain degree prior to arrival. AH typically place them into lower level roles, with support and opportunities to shadow where possible. Senior doctors often struggle when taking up these positions, however they are made aware of the level of post once they are selected:

I mean, my job description was definitely a lot different. It had got responsibility and things in my country compared to now, because I'm working now at a more junior level. [OMG15_NON2_INT2]

OMGs need to take responsibility, along with the organisation, in ensuring that they are comfortable with the level that they have been appointed. In collecting performance data through the EG database, it became clear that there were many different terms used for the same level of doctor. This confusion about job roles (C), created further anxiety for OMGs (M):

…you sort of look at FY2, LETs and then FY2 LETs and then Trust Doctor and clinical fellow and it's basically all the same posts, but just described differently. It sort of looks like a maze and you think, you know, what am I to do, like, you know? How can I navigate…? when you're outside it and looking at it from a foreigner's point of view, it can be quite daunting. [OMG17_NON2_INT2]

Some OMGs felt a loss of identity due to the confusion, particularly Trust Doctors (C):

Because the thing with Trust Doctor posts as well is that they're so diverse. Like, I was an F2, technically, as a Trust Doctor and I was working with Trust Doctors that had completed their core training and that were just doing a CCT post until they could get into higher training. And staff and people all look at you as the same type of person, which is an SHO, but the amount of things that you know and can do vary greatly. Because in core training people understand when you say, "I'm a CT1." "Oh, you've just started." "I'm a CT3." "You're more experienced." But when you're a

Trust Doctor, no one knows the difference really…Trust Doctor doesn't mean anything. [OMG17_NON2_INT2]

…it's not very clear. Because I came in, my initial post was, is a Trust post, but I'm in a training post now, so I don't know technically on paper what I am, probably Trust. Because I'm not part of the college training programme, but I'm supposed to be a trainee so… [OMG15_NON2_INT2]

OMG acceptance of their job role:

Chapter 7 illustrated that OMGs need to accept that they may need to start at a lower level and progress from there (C):

They will big themselves up. They know how competitive it is. [Supervisor2_OMG20_POD2_INT2]

Well, in a way it's good. In a way it's good because I'm getting to know the system from a very junior level so I'm getting to know all the core work. [OMG14_NON2_INT2]

Those who were more senior struggled most with this, feeling disappointed that they had to uptake a lower position (M):

I realised that I am taking blood from patients and I'm doing a physical examination. This is not stuff I was doing back in India because I was working at the junior consultant level, so this is what my juniors were doing. But because I didn't know the level, you know, so I just got the job and I took it and then I realised, OK, this is not what I wanted. Because right now I'd like the job of a speciality doctor and I realised that after I had got into this job. So then I started applying, but at that time when you sort of apply and you get the jobs, that had gone. So I sort of washed up into this one, so I lost a lot of time. [OMG14_NON2_INT2]

Where job roles were not accepted, this led to resistance (M) and would have likely led to patient safety issues (O):

…we will need to start in a low level of course and we totally respect that, because the lower level here is one of the highest in Greece I have to admit. I mean I came in here having completed my training and I have to say that I'm about 75% of the level that these guys are here and they're fully trained. So there's a lot of things to learn here, absolutely…some people don't like that. That's true, I know, I know, they don't survive here with these mentalities. You have to respect it. [OMG13_NON2]

…and the thing that they're not any good at is saying, I can't do that, because they want to fit in desperately, don't they? [Expert1]

OMGs found it hard to adapt to lower roles as they felt that they would be viewed as having limited knowledge. This feeling hindered their self-esteem and self-efficacy (M) which led them to feel unable to speak up in practice. OMGs discussed how this led to performance

issues on the ward (O). Although issues were resolved, it led to their own perception that they had gone 'backwards' and not progressed in their career (M). Such feelings also led to frustration and a risk of leaving the job (O).

A lack of insight and acceptance of job roles had a negative impact on how OMGs perceived themselves and how they thought others perceived them. This perceived lack of role identity within the organisation will likely hinder adjustment to the workplace.

8.3.3.4 Preparedness for practice and expectations

Those who were not prepared for practice (C) often lacked understanding about UK practice (M), which led to performance issues and hindered retention (O):

> *One guy came in at core training and he was unable to meet the requirements. He had to go home actually. You give them the two years, maybe an extra six months. If they don't meet the requirements, they're out, you know. [Supervisor2_OMG20_POD2_INT2]*

Senior doctors, despite not always identifying it themselves (section 8.3.3.3), were often unprepared for practice in the UK as they had been in a specialty for a long time (C):

> *Well, I did my basic medical training in Sri Lanka, but I just did work in psychiatry for some time over there before I came. So I'm not here after my basic training, so my knowledge of medical and surgical sort of management and my skills are quite old and not really up-to-date because I've not needed them for some time because I've been in a speciality, you know, where you don't need them, basically. [OMG15_NON2_INT2]*

However, overall this research illustrated that doctors were largely capable in terms of their clinical performance (section 8.2.2 highlighting no difference between UK graduate and OMG practice):

> *I think the only thing she didn't have was a working knowledge of the NHS and some simple things…She's quite an experienced doctor, a very good doctor, from working abroad anyway, very good. [Supervisor_OMG18_POD2]*

Experts from the GMC agreed with this:

> *Oh absolutely, they're very clinically expert…usually they're very senior doctors in their home countries. It's not that they've got an issue with. It's just they come sort of helicoptered into a very strange world really! [Expert1]*

Although clinical skills training was not the focus of POD, OSCEs were added to POD2 to highlight training needs in areas that were thought to cause difficulty to OMGs (M), such as

inserting cannulas. These OSCE stations also addressed communication skills. OMGs noted the need for such training, thus illustrating a successful refinement to POD:

> *I mean you can probably gather a set of basic skills that one should have, like you mentioned IV cannula and other things, maybe a short course on reading ECGs or things like that. And just have a few hours of small training sessions especially for foreign doctors. That definitely helps. [OMG17_POD2]*

Cultural differences impacted upon preparedness for practice (C), some not having the necessary insight into UK practice (M):

> *So if you are coming from Africa or India, Pakistan, Bangladesh, the disease pattern is different…here you see lots of COPD, you don't see that. Here you see lots of strokes and coronary artery disease, it's less. I mean it is on the rise but still you don't, so their main emphasis there for their training is dealing with infectious disease is a first priority, is less of a worry here. So they need to learn because suddenly they have to change and learn new things…just general support can help with that and if somebody has qualified as a doctor then they pick up those things pretty quickly. [Supervisor_OMG16_POD2_INT2]*

Specific issues became apparent for those doing psychiatry (C):

> *I sort of can remember the first month or so, going home every day after work and sort of having to Google things that were mentioned. Sort of, even, you know, the bread and butter psychiatry really that everyone thinks you should know, like section 2 or 3, or section 117…. [OMG17_NON2_INT2]*

> *So that was very difficult because I had to learn that on the job then, you know. I mean, I assumed things would be different, but not to this sort of level, you know. I seem to have a lot of problems when trying to communicate what I'm seeing. And, you know, they don't understand why I can't tell them what the Wells score is, but it's because I've not heard of the Wells score, basically. And I have the skill; I can do it. But I don't know where all the little things go, you know, and what to do with the little things. So all of these things have been really challenging. [OMG15_NON2_INT2]*

Interventions like POD can target a lack of knowledge and understanding (M):

> *I think it could be maybe addressed by just a simple sort of maybe a one day session of teaching sort of, you know, going through all of these things and introducing actually what we need to know or what we are expected to know in this country at this level. [OMG15_NON2_INT2]*

This section further supports the notion that individual needs must be taken into consideration when training and supporting OMGs.

8.3.3.5 Capacity to change and identification of needs

Resistance to changes in practice:

Some supervisors felt that culture had an impact on how receptive individuals were to change (C). UK, International and EU graduates were thought to respond differently to changing their practice (M):

> *And they [UK graduates] start complaining to the consultants and criticising the consultants. They forget that we have years and years of experience which makes a lot of difference in difficult situations. They don't respect us once they pass exams. Whereas Indians, they maybe a little bit arrogant when they first come, but they know that they have to change. They can't progress if they don't change their attitude. So they are forced to change if they want to progress. But at the same time, now we see a lot of European doctors, they think it is their right to be in England, you know. I have it from one European doctor from Romania. He's always comparing his country doctors with the English doctors. You know, he's always distracted about this and it's very irritating that you don't focus on the job, other than debate about what is good for you and what is good for us.* [Supervisor_OMG20_POD2]

Some OMGs were reluctant to change certain elements of their practice (M):

> *I've been open about the fact that it's been difficult. But I believe it is a reluctance to do it from me…in my country you don't even get a cannula. But here, the acute Trust would ask us to cannulate a patient sometimes before sending them over. I've been quite reluctant to do that, simply because of this. But, you know, being forced to do it, I've usually got one of my junior colleagues to kind of show me how to do it [OMG15_NON2_INT2]*

Capacity to change was very much linked to individual differences discussed in section 8.3.3.2 (C).

Identification of training needs:

During POD2, some OMGs raised the concern that patients were often unfair to them in terms of making complaints against them. However, following POD, OMGs understood the need to reflect and assess their practice, regardless of their initial perceptions (M) (which may be linked to culture). Questionnaire data highlighted that all attendees agreed that CPD was essential and were motivated to learn about good practice (M). Those who seemed to be less responsive in the POD sessions illustrated that they identified the need for such training, offering to help with future implementation (M):

> *Me and my friend, we were wondering that in case you need our help in a couple of presentations or at least one presentation to deliver to the new people. [OMG15_POD2_INT2]*

Those who had the capacity to change, and could identify their needs (C), engaged most with the support offered by POD (M). However, where support was lacking in terms of a specific interventions or supervision, it was even more important that OMGs had a capacity to change (C) as it meant that they actively sought to understand UK practice themselves (M) and could then progress in terms of their performance and career (O):

> *I was just looking at others and I was making mistakes and learning from that. And as I say they're not exactly telling me what I should do. Fortunately no fatal mistakes. It is difficult to change, but, you know, I'm a doctor today and I've been changing all my whole life…so I was just talking to people to see what they are doing and what I should do, what I should follow. I was worried about my progression in my practice and, you know, I've got goals for myself, I want to reach to that point, but if nobody's guiding me and I'm not aware of it. This system is complicated, there are so many rules. And when you want to learn about them then you face loads of pages that you have to read through at the beginning when you see that it's OK I'm not going to do that. So if you don't read, you don't know, and nobody's telling you, so you won't learn at the end of the day, so nobody's taking your hand. But I'm more comfortable with what I'm doing, because I know a few rules now and I've been to some courses for foreign doctors for communication. [OMG16_NON2]*

> *I guess if someone isn't that switched on, or they're a bit more timid, they're just not engaged in that. You know, because your consultant isn't going to come up to you and say, you know, "You need to do this" because they're swamped in their own paperwork. So you have to go and sort of pester them and say, I need you to supervise me while I do clinics so we can sign these off so I can take them to training interview in six months or one year's time and be able to get into training. [OMG17_NON2_INT2]*

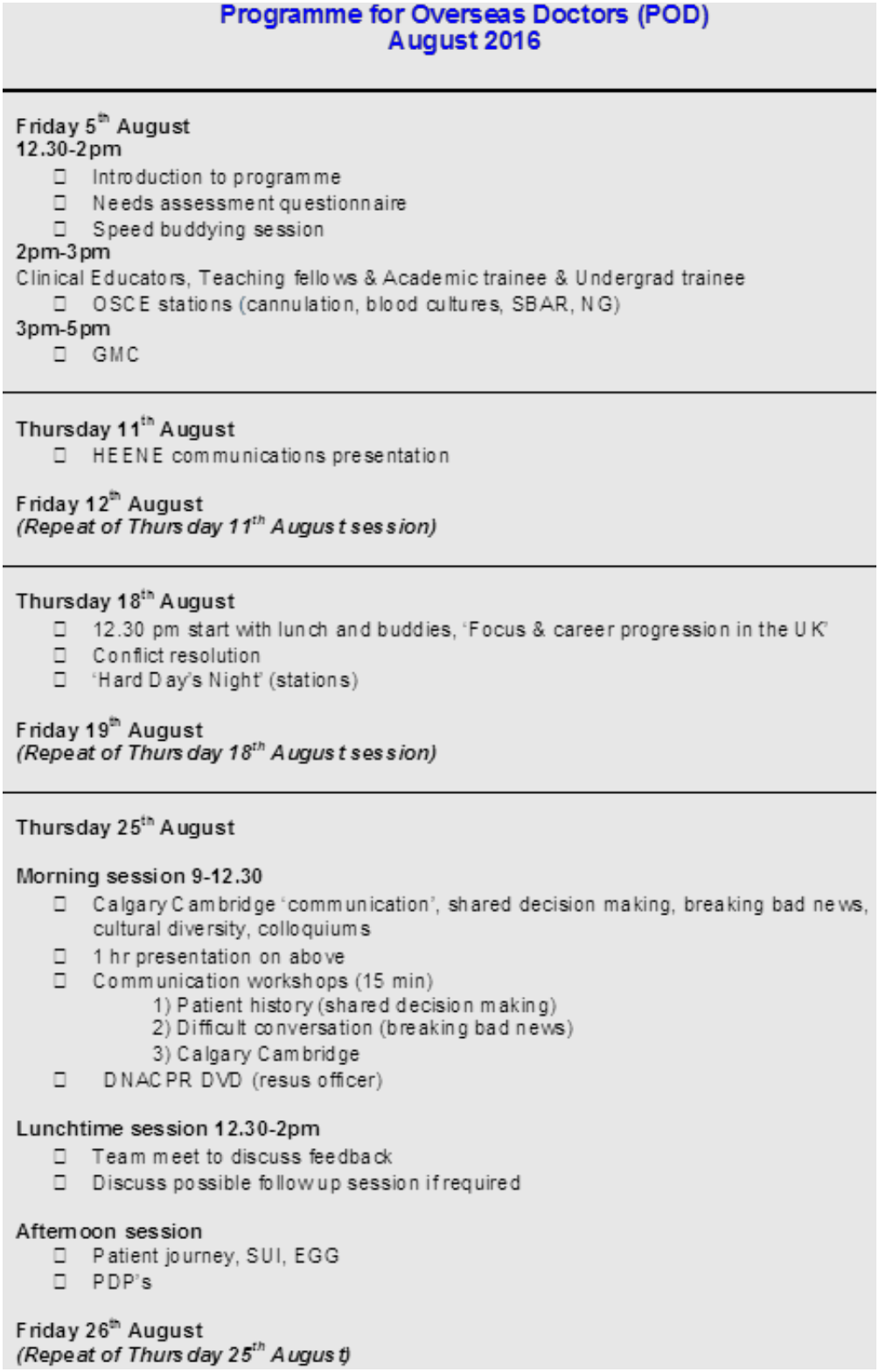
The findings here very much support the concept that OMGs must be able to identify their learning needs and have the capacity to change their practice.

8.3.3.6 Summary of individual factors

Individual needs were taken into consideration when training and supporting OMGs at AH. This was important as individual differences impacted upon how OMGs perceived themselves to fit into the system, whether they could identify their needs, and what barriers they perceived to affect their adjustment to UK practice.

8.4 POD developments

The refined version of POD is illustrated in Figure 25.



Programme for Overseas Doctors (POD)
August 2016

Friday 5th August
12.30-2pm
- Introduction to programme
- Needs assessment questionnaire
- Speed buddying session

2pm-3pm
Clinical Educators, Teaching fellows & Academic trainee & Undergrad trainee
- OSCE stations (cannulation, blood cultures, SBAR, NG)

3pm-5pm
- GMC

Thursday 11th August
- HEENE communications presentation

Friday 12th August
(Repeat of Thursday 11th August session)

Thursday 18th August
- 12.30 pm start with lunch and buddies, 'Focus & career progression in the UK'
- Conflict resolution
- 'Hard Day's Night' (stations)

Friday 19th August
(Repeat of Thursday 18th August session)

Thursday 25th August

Morning session 9-12.30
- Calgary Cambridge 'communication', shared decision making, breaking bad news, cultural diversity, colloquiums
- 1 hr presentation on above
- Communication workshops (15 min)
  1) Patient history (shared decision making)
  2) Difficult conversation (breaking bad news)
  3) Calgary Cambridge
- DNACPR DVD (resus officer)

Lunchtime session 12.30-2pm
- Team meet to discuss feedback
- Discuss possible followup session if required

Afternoon session
- Patient journey, SUI, EGG
- PDP's

Friday 26th August
(Repeat of Thursday 25th August)

Figure 25. The Programme for Overseas Doctors (POD) implemented at the Amity Hospital (AH) 2016

Further changes to POD, following the overall evaluation findings, are discussed below.

- Following POD2, the Trust Doctor Tutor took charge of POD to ensure sustainability and oversee future developments. The POD planning team were aware that the Clinical Director of Education could not continue to lead the intervention. The Education Department also ensured evaluation continued.
- Attendance at POD was made mandatory for all OMGs in new training posts at AH. It was highly recommended that all OMGs new to UK practice attend. It was also suggested that supervisors should identify OMGs currently practicing that would benefit from POD; supervisors and OMGs can discuss which elements of POD to attend based on individual needs. Locums that would benefit from training should also be identified.
- Raising awareness of POD continued to ensure recruitment of OMGs. The POD planning team invited other Trust educators who were interested to attend a planning meeting and get an idea about what the programme involved.
- The process for managing Trust Doctors on the system was further developed by the Trust Doctor Tutor and HR. This made it possible for the Trust Doctors Tutor to meet with Trust Doctors within the first two weeks of their arrival.
- A 'welcome pack' was developed that all OMGs would receive on arrival, including important information and online learning modules. The increased link with HR meant OMGs could receive it sooner.
- Guidelines were developed to try and add more structure and ensure successful implementation of POD at AH (including guides for organisational development, training, supervision and buddying).
- Communication skills training delivered by educators at AH was developed to include more role-plays.
- The OSCE stations were developed to cover more competencies that OMGs may need to develop, such as blood cultures/transfusions and documentation that is required alongside such procedures. They also focused on communication scenarios, such as disclosing error and handover to colleagues. An unmanned station was also added that explored other common assessments, reviewing of medicines and completing a death certificates.
- It was recognised that a more robust system was needed to monitor the buddying system; to ensure all OMGs entering the Trust were offered a 'buddy' figure. 'Buddies' were identified through POD, supervisors and the Education Department.

Yet due to the increased awareness of OMG needs in the hospital, more support was offered and relationships tended to form organically.

- It was highlighted that the Professional Development Plans (PDPs) that were completed at the end of POD needed to be fed back to supervisors, therefore the team pushed for increased supervisor involvement.
- Enhanced supervision training was implemented for all supervisors to ensure that they were providing adequate support for OMGs. OMG needs were highlighted and discussed with supervisors (including findings from this research). Awareness about the need for POD and 'buddies' was further discussed. This meant that supervisors were more likely to reflect on PDPs and discuss any issues that POD may have raised. It was hoped that this would become normal practice. The training also looked at what supervisors felt they needed in terms of working with OMGs. Supervisors who attend the training received recognition for doing so; an Enhanced Supervisor status. It was hoped that providing extra support for those who need it would not need further incentive.
- A competency form was also given to supervisors and educators to fill in so that they could monitor progress of OMGs. This meant that further training needs could be identified.

Developments outside of AH also occurred following these findings:

- Links were made with HEENE to ensure that there was shared responsibility between local and regional levels in facilitating OMG transition in the future. The POD planning team recognised that there was no point in overlapping training sessions. It was proposed that HEENE could provide key information in their regional induction and that individual Trusts could deliver more of the experiential learning and ongoing support that has been identified as necessary in this research. Resulting from the findings in this research, HEENE have developed their OMG induction and have developed a 'train the trainers' workshop for those supervising OMGs. Educators from HEENE were very much astonished at the reaction of OMGs who attended their developed induction in 2016, not realising how grateful they would be.
- It is also under discussion as to how HEENE or the GMC can help Trusts to identify OMGs new to the UK.
- The GMC hope to collaborate with the POD planning team and myself to try and facilitate implementation of local interventions and ensure ongoing support. However, it is recognised that changing culture is difficult.

8.5 Summary of findings - synthesis of all research data presented in this thesis

The overall findings very much support the middle-range theories presented in the realist synthesis (Chapter 4). The programme theory highlights the importance of, and difficulty caused by, interactions of the identified individual, training and organisational factors. Whilst the three levels of contextual factors have been presented separately (for ease of the reader and use for implementation), the levels do interact a great deal (evidenced throughout). It is this interaction that is thought to lead to successful OMG transition, including general adjustment that was absent from the realist synthesis findings. One level should not be working in silo, for example, skills training will not adequately support adjustment if resources are not available to ensure ongoing support is offered or if the individual is not motivated to learn.

Whilst the organisation has the responsibility to support OMGs as much as possible and ensure they know what is expected of them in UK practice, it is also the responsibility of the individual to be open and realistic about their training needs, and seek help if needed.

Local level implementation was most successful in facilitating OMG transition. Many of the OMGs that attended regional interventions illustrated that their transition was very much hindered due to the lack of support in the workplace. This highlights the importance of local level factors outside of the intervention itself. The training level would typically be the focus for many intending to implement an intervention like POD, often focusing on the first box presented in the training level (see Figure 23). Despite the content and ongoing duration of POD being effective, support networks that were established outside of the intervention itself, particularly with peers (both UK and OMGs) and supervisors, helped to facilitate the transfer of learning and overall transition. This was evident in interviews with the non-intervention group at AH (supported by poor retention and career progression). Many had moved from other Trusts in the UK and noted the importance of the supportive environment at AH in aiding transition. The need for this level of support, outside of POD, may explain the fairly low level of incident rates for OMGs that both attended and did not attend POD. The findings also highlighted that rate of incidents dropped following POD2, perhaps due to improved organisational awareness and culture. Retention rates and career progression was also high for all OMGs at AH.

It was evident throughout that the level of support perceived to be needed by each OMG was dependent on their individual needs. Trust Doctors have been identified as a group most at risk during their transition; POD successful supporting their transition in terms of

performance, career progression and retention. This group of OMGs tended to utilise the extra support offered the most, for example buddying (particularly those who had newly moved to the UK or felt support in practice was lacking). This was also linked to the culture of the organisation; some OMGs (particularly more senior individuals) felt able to seek support from peers and supervisors if they needed it, without additional buddying. Engagement, motivation to learn and resilience, were also dependent on individual factors such as personality, incentives, role identity and capacity to change.

Barriers at the organisational level, related to resources, workload and recruitment, hindered implementation in many of the cases discussed. However, regional and national support could help to facilitate successful implementation at the local level. AH already had a culture that was extremely supportive towards OMGS, this being key in facilitating the implementation and success of POD. The implementation of POD led to an even more supportive environment following increased awareness of educators, supervisors and peers. This resulted in a variety of safety nets for OMGs.

As discussed throughout this research, and evident from the complexity of Figures 22-24, there are many factors to consider when implementing interventions for OMGs.

Chapter 9 Discussion

9.1 Outline

This final chapter will begin by summarising and explaining the refined programme theory following synthesis of all data, illustrating how its development has led to the aims and objectives of the research being met. The focus is very much on theory; exploring why interventions were successful, why some interventions have not been successful, and what future implementation should consider. The discussion will then explore the implications of the proposed theory and explain what the findings mean in relation to the literature, practice and policy. Recommendations for policy and practice are given, highlighting how interventions can be developed and improved in the future. The importance of the realist approach within this project will also be explored. Strengths and limitations of the overall study will then be highlighted. Suggestions for further research in the area will be proposed. The chapter will conclude by presenting the impact of the findings to date; illustrating how the remaining research objectives have been answered.

9.2 Recap of research aims and objectives

Aim

This research aimed to explore and evaluate interventions that have been developed to support the transition of overseas medical graduates to the UK. This was achieved through a realist synthesis of literature and a realist evaluation of an intervention that was developed in one North East Trust.

Objectives

- What interventions and services are provided to support the transition of overseas medical graduates to the workplace?
- What barriers may hinder implementation of interventions?
- What were the outcomes of not having adequate training and support interventions in place?
- How and why are interventions effective (or not effective)?
- What factors are vital to the success of the intervention?
- What barriers may hinder transition and how can they be overcome?
- What are the theoretical explanations that may be applicable?
- How can interventions be developed and improved for future implementation?

These objectives have all been met. The realist synthesis presented in Chapter 4 explored the available interventions and services that were developed to support the transition of OMGs to the workplace. Initial middle-range theories were developed. Findings highlighted the need for ongoing support. These were then refined during the realist evaluation of the developed Programme for Overseas Doctors (POD) (explored in section 9.3). Evaluation of POD highlighted key facilitators and barriers to successful interventions, and outcomes of not having adequate support in place (discussed in section 9.3 and 9.4). Exploration of how interventions can be developed and improved for future implementation are discussed in section 9.5 and 9.10.

9.3 Exploration of the programme theory

This research has begun to extend the knowledge base on OMG transition and explain how interventions can support OMGs. The project involved intervention planning and implementation, alongside theory building. All activities took place simultaneously throughout and the process was iterative. Theoretical explanations exploring interventions to support OMGs were significantly lacking within the literature[53] and therefore the developed programme theory has added an original contribution to knowledge. Policy makers, healthcare organisations, educators and OMGs are also provided with a framework to assess OMG transition into the NHS. The focus of this framework is on contextual factors that need to be in place to activate the necessary mechanisms that will likely lead to adjustment outcomes. The programme theory ensured that the research aims and objectives were met.

9.3.1 Overview of findings from each chapter

Chapter 1 illustrated the need to explore OMG transition further and to develop theoretical explanations as to how interventions can effectively support transition. Ensuring OMGs make a successful transition into the NHS is a complex matter that requires deeper insights into the nature of interventions and implementation contexts[113, 124]. What works for one OMG, or one hospital, may not work in another one. Complex interventions like POD are also difficult to design, implement, and evaluate. That is why it was essential to consider how, why, for whom and in what context interventions for OMGs would work. A realist approach was adopted to ensure the research objectives were met. Middle-range theories were developed using relevant empirical and theoretical literature (Chapters 2 and 3). As theory was identified as being missing from the literature[53], a more rigorous and deeper theoretical understanding about interventions specific to OMG transition was required through the

realist synthesis presented in Chapter 4. The middle-range theories that were posited in Chapter 3 were developed through the findings from the literature explored in Chapter 4 (discussed in detail in section 9.4.1). The realist synthesis illustrated that a number of interventions had been developed to target OMG needs, however the majority were limited in terms of ongoing support. Within the UK, the main source of support offered to OMGs equated to a half day induction[41]. Unlike the developed intervention at AH, the interventions did not fully address OMG needs and instead offered limited support for what was an ongoing issue (issues discussed in Chapter 6). Furthermore, many OMGs were unaware that support was available, or could not take part in the intervention due to workload or travel. Robust evaluation of the success of these interventions was also lacking. Overall, the initial findings illustrated that three contextual levels were essential for OMG transition; organisational, training and individual.

To explore the three levels and their interactions further, a realist evaluation was conducted. This provided an opportunity to test the theory developed from the realist synthesis using primary data and within specific contexts. Evidence was sought to both support and challenge the theory. Findings from Chapter 7 supported the theory developed from the realist synthesis and further explained how the three contextual levels contributed to the success of POD. Findings from Chapter 8 helped to further refine the theory. The programme theory is summarised below.

9.3.2 Summary of the programme theory

Organisational level:

The findings highlighted the need for organisations to look at OMG transition at a higher level. Organisations will likely be setting up to fail if contextual issues are not assessed prior to the development of interventions. Contextual factors at the organisational level will guide the development and implementation of interventions (and general support) offered to OMGs. Local level implementation would be most effective in supporting OMG transition, however this is hindered by organisational barriers (such as inability to identify OMGs or the context of the work environment). The proposed theory suggests that interventions will require investment in resources and leadership. The need for regional and national support is therefore highlighted. Exploration of comparison case studies, where levels of support varied, further illustrated the importance of higher level input.

A supportive and open culture within the individual organisation is likely to be crucial to the success of interventions to support OMG transition. The culture at AH very much facilitated

the success of POD, the high level of ongoing support becoming the norm there. All staff (supervisors and peers) engaged with change and absorbed the developing culture. As a result, ongoing support was given to OMGs at the training level, both through the intervention itself and back in practice. Participation in POD was not seen as negative by OMGs at AH and encouragement was given by supervisors and peers to attend. Support for POD also increased following these evaluation findings and dissemination throughout the Trust (all levels).

This culture may explain the low level of untoward incidents reported for OMGs, evidenced during the realist evaluation. In fact, incident rates for UK graduates was found to be higher than for OMGs when performance data was analysed in the second year of evaluation. Overall, POD was thought to have facilitated performance, retention and career progression of OMGs at AH. Increased patient safety and reduced work burden for all staff is implied by these successes. Comparator Trusts illustrated that a lack of such an intervention, and necessary support structure, likely hindered these outcomes within their organisations.

Training level:

Contextual factors at the training level are associated with the implementation of the intervention (e.g. content/design/support network) and training external to the intervention (e.g. levels of support in practice - supervisor/peer/training support). Initial experiences of working in the NHS are important for OMGs in their transition. If support is in place from the initial phase of transition, negative experiences are more likely to be overcome and OMGs are more likely to adapt to UK practice. A lack of adequate and ongoing support for the OMG will likely result in poorer performance, poorer career progression, and lower retention. Brief transitional interventions, such as an induction day, are not enough to support OMG transition. An extended amount of time, effort and dedication is required from all levels. This is evidenced by the data (triangulation): OMGs at AH were able to make a successful transition. Most of those in the non-POD group had been exposed to some induction or training for overseas doctors, yet they still struggled.

Tailored intervention content at the local level will ensure individual needs are met. This is important given that individual factors will facilitate the success of intervention efforts. As an example, some participants during POD had initially been slightly resistant (due to factors such as status and identity), however following experiential learning opportunities and feedback, self-awareness increased and they ultimately saw the need for the training.

Individual level:

Contextual factors at the individual level, experienced by the OMG, will be a key factor during their transition. Examples include role identity, capacity to change and individual differences (e.g. culture/personality/length of time living in the UK). Awareness and understanding of the proposed individual factors is important at both the training and organisational level, as well as for the OMG themselves.

Many OMGs, particularly Trust Doctors, felt they were merely filling gaps created by staff shortages and were not supported (career progression and recognition of previous skills and culture is important); and that their needs were not being met. OMGs also need to be motivated to learn and be aware of any difficulties in practice. These difficulties need to be managed in a sensitive manner and OMGs supported to progress. Individuals are then more likely to take responsibility for their own learning and engage in available support. Assumptions should not made about OMG abilities, for example, if they have good language skills, or assessments have been passed, then they may not need a high level of support.

Complexity and interactions:

The programme theory illustrates the complex process of OMG transition. The purpose of the cogs used to present the theory is to illustrate that the smooth working of each level is dependent on the other levels working well too. Each level is unlikely to be working in silo; findings at each level interact and impact upon each other. Likely outcomes resulting from good interaction include performance (including incident rates), retention (satisfaction), and career progression. Overall general adjustment to the UK is also likely to occur.

The realist synthesis, along with discussions with experts, identified that countries outside of the UK had more robust systems in place to support OMG transition. However, discussions highlighted that many organisations struggled to recruit OMGs to take part in the intervention and the interventions were not always sustainable. Intervention leads have asked how POD was successful in recruiting and engaging OMGs, and other staff, within the organisation. The findings suggested that all levels had a part to play. Organisational factors, particularly culture, played a vital part in this, facilitating the level of support offered outside of the intervention. As the profile of POD was raised and it became more established within the organisation, supporting OMGs in this way became the 'norm' at the training level (outside of POD). As a result, OMGs were likely to engage with the support offered, be accepting of feedback and overcome barriers posed at the individual level (such as capacity to change). This highlights that whilst the intervention within the training level may be in

place, this alone will not facilitate learning; learning itself and transfer of learning into practice. One attendee from POD 2016 illustrated the importance of the interaction of all levels during group discussions (see Box 6).

Box 6. Discussion with POD attendee (2016) about their initial experiences within the NHS

Initial experiences transitioning to the NHS

The organisation that the OMG had worked for previously lacked support and as a result, they felt they could not ask for help. Initially they had asked for help but faced negative reactions. They did not know what their job post was, what they should be doing and consequently managed alone for six months. When it was highlighted that they were not practising correctly, they were not shown, or given information about how to do it correctly. Many assumed they lacked insight and competencies. Again, they did not want to ask if they did not know. There was also no career focus and they felt that they were just doing the job to fill gaps. They did attend the regional intervention provided by HEENE, where information was given, however there was no support when they went back to practice. With no progression or opportunity to build a career, they left. When they began working at AH, peers (including a 'buddy') and supervisors were supportive. Supervisors were helpful and pushed them to get their competencies so that they could enhance their career opportunities. POD provided an opportunity to share experiences, gather essential information and led to lasting friendships. Small issues like paperwork, caused anxiety previously, but at AH they felt able to ask peers (and their 'buddy'). They recognised that interventions like POD could not provide all information that was needed, however it made them feel more confident in asking if they were unsure. The depression that they felt was also alleviated.

9.3.3 Overview of key facilitators

Facilitators have been discussed in section 9.3.1 when presenting the programme theory, however this section will now explicitly illustrate key facilitators found to impact OMG transition. The focus here is on highlighting essential mechanisms that need to be activated by the context to ensure successful interventions and overall transition.

9.3.3.1 Organisational level key facilitators

- Enthusiastic and committed leadership, along with ongoing investment (including evaluation) and availability of resources, will lead to the successful development of an intervention to support OMG transition. The development of the intervention within the organisation will lead to OMGs being satisfied with the organisation and increase their level of commitment to the organisation.
- Where all staff are made aware of the intervention, resulting from a high level of dissemination, support for the intervention and awareness of OMG needs will likely rise (from educators, peers, supervisors, OMGs etc.). OMGs are more likely to engage with the intervention if a high level of support towards their transition is perceived. Investment of resources in support will increase OMG knowledge and understanding, their satisfaction, reduce initial stress and increase their confidence in the organisation.
- Where a supportive culture is already in place within the organisation, interventions are more likely to be accepted and overall engagement will increase. The drive towards supporting OMGs will further facilitate the long-term change to a supportive culture, with a focus on career progression being necessary. This will help to facilitate *Cultural Health Capital* (wellbeing, resources, resilience, optimism), overall satisfaction and commitment to the organisation; enhancing overall wellbeing.

9.3.3.2 Training level facilitators

- A rigorous training programme or induction is essential. OMG engagement with interventions will increase if their individual needs and expectations are met (culture, UK practice, communication, career progression etc.). Experiential learning within a safe environment and small groups will facilitate learning; increasing self-efficacy, *transformative learning* (self-awareness, beliefs, behavioural) and reduce anxieties.
- Ongoing support (peer, supervisor and training) is important, both during the intervention and back in practice. Having supportive and empathetic figures will ensure Cultural Health Capital and transformative learning occurs; facilitating OMG engagement, self-efficacy and the transfer of learning into practice. Encouragement from supervisors towards career development and training is important. Organic relationships with both UK graduates and other OMGs will ensure both bridging and bonding social capital.
- Creating a support network and a sense of being welcomed to the NHS (and organisation) will facilitate a sense of belonging and satisfaction. As discussed with peers and supervisors, this extra level of support will also facilitate transformative learning and transfer of learning to practice.

9.3.3.3 Individual level facilitators

- OMGs who have the capacity to change may be better able to identify their needs and hold realistic expectations about practice in the UK. These OMGs may be more motivated to learn and ultimately be more resilient to negative experiences. Having this insight will facilitate learning and transfer to practice.
- OMGs who have a clear role identity, and are accepting of this role, are more likely to be motivated to learn, have insight and take responsibility for their learning.

9.3.4 Overview of key barriers

This section highlights key barriers to OMG transition. Focus is on mechanisms activated by the context that were found to hinder the success of the intervention and overall transition.

9.3.4.1 Organisational level barriers

- Interventions often focus on organisational needs (e.g. patient satisfaction) rather than individual needs of the OMG. Where OMG needs are not met, OMGs are less likely to engage with the intervention. Ongoing support is also likely to be missing from interventions that do not address all needs, possibly reducing satisfaction and commitment to the organisation.
- A lack of resources and high workload is a major barrier to the implementation of interventions and will hinder the amount of support that can be offered to OMGs back in practice (limited training, peer support or level of supervision). Engagement with available interventions will be hindered by high workload and staff shortages. OMGs and supervisors may also be unaware of available support and resources due to poor dissemination. Not engaging with available resources or support will likely hinder OMGs' acquisition of knowledge and understanding, increase initial stress and reduce confidence in the organisation.
- The absence of a change champion and poor leadership that does not push for a supportive and open culture will hinder intervention success. Where this culture is not in place, OMGs may face alienation and may not have the opportunities to build their Cultural Health Capital. Self-esteem is also likely to decrease, meaning they are also unlikely to seek help in facilitating their knowledge and understanding. Overall satisfaction and commitment will likely decrease because of negative experiences.
- If the context of the work environment leads to initial negative experiences for OMGs, such as rural location or lack of resources, this is likely to hinder intervention success. Level of support available and transfer of learning may be hindered by high levels of staff turnover and mobility in posts (particularly Trust Doctors who move around). This instability and lack of supportive environment, ever growing within the fragmented NHS, may lead to feelings of alienation, lowered self-esteem, stress and overall dissatisfaction. It is also unlikely that OMGs will be given opportunities to increase their Cultural Health Capital or confidence.
- There are many barriers to OMG transition that cannot be controlled at the local, or even regional level. These barriers will also impact upon intervention success. Examples include monitoring and recruitment of OMGs, barriers faced when entering the UK workplace (particularly international graduates), and job roles (particularly the issue of Trust Doctors who may get lost in the system). These factors will likely hinder confidence, overall satisfaction and knowledge/understanding. Stress levels will also likely increase.

9.3.4.2 Training level barriers

- A lack of ongoing support (from peers, supervisors and in training) will largely hinder transformative learning and transfer of learning into practice. As a result, OMGs may not engage with necessary training or acquire the social capital and Cultural Health Capital needed for adjustment. This will likely limit knowledge, understanding and self-efficacy, whilst also increasing stress and anxiety.
- When OMGs face initial negative experiences, not feeling welcomed or part of a support network, the above mechanisms will be hindered further. An example of this may include inappropriate complaints and perceived prejudice. OMG satisfaction will also likely decrease and they may feel that they do not belong in the work environment or even the country.

9.3.4.3 Individual level barriers

- If OMGs perceive barriers to interfere with their adjustment, such as a sense of bias towards UK graduates (prejudice), this will lower self-esteem and lead to increased stress and anxiety.
- Due to individual differences (for example personalities or different family circumstances), some OMGs may need more help to adapt and acclimatise than others; the focus should not be on competencies alone. OMGs may face more stress, heightened anxiety and be less resilient to negative experiences. Individual differences may also hinder motivation to learn and lead to resistance to engage with support.
- An OMG's role identity should not be expected to be a model of adoption or shifting of cultural views. If this is perceived by OMGs, they may be resistant and unmotivated to learn, leading to anxiety and stress. This is likely to be particularly important for older and more experienced OMGs, who may not have insight into their adjustment needs. If OMGs do not understand their role within the workplace, for example Trust Doctors who feel that they are merely filling gaps, they are also less likely to acclimatise. Where a preferred role identity is perceived to have been hindered, this may lead to lowered self-esteem and self-efficacy. Regardless of clinical experience in their home country, a period of adjustment is needed.
- OMGs who are not prepared for practice within the UK or whose prior expectations are not met will likely have poor insight, leading to disappointment and resistance to adjustment.
- Different cultures and experiences will likely impact upon OMGs capacity to change and ability to identify their needs. Where stigma is associated with being from overseas, OMGs will be more resistant to engaging with extra support and less motivated to learn. This will reduce insight into their needs and UK practice further.

9.4 Implication of findings

This section discusses the key findings of this study in relation to findings evidenced in the empirical and theoretical literature. Exploration of the findings in relation to current policy and practice is also discussed. This section highlights the impact of findings on the wider field of knowledge.

9.4.1 Implication of findings for empirical literature

Prior to this thesis, research was needed to understand the most effective ways to optimise and facilitate OMG transition[135]. Evaluation and evidence were very much lacking[53]. As a result, the literature illustrates substantial differences in terms of supporting OMG transition[11, 53]. To date there is inconsistency in how integration is approached in different organisations and how much attention is given to the different levels proposed in this thesis (organisational, training and individual). However, some literature does support many of the individual concepts proposed in the theory (discussed below).

9.4.1.1 Support for key concepts within the literature

The findings from the realist evaluation of POD support much of the literature presented in the realist synthesis (Chapter 4). Emphasis is placed on the need for non-stigmatising interventions to target individual needs[14, 25, 158, 185, 192, 209, 216, 217, 295] and ensure that ongoing support is in place to offer an iterative process of learning that continues following interventions[98, 143, 153, 209, 211, 214, 215, 218, 224, 233, 237]. Organisations must embed transition activity within a longitudinal lifecycle model[296]. Interventions are likely to be most successful if there is a supportive culture already in place[143, 145, 158, 185, 192, 195, 209, 217]. Investment in resources and support for interventions from all levels will also facilitate success[89, 102, 135, 297]. OMGs are more likely to have self-motivation and engage with learning if the social conditions of the work environment facilitate autonomy, competence and relatedness[298]. Other individual level factors will also impact upon learning and intervention success[14, 56, 73, 145, 188, 189, 195, 197, 200, 201, 204, 213, 217, 224, 251, 256] (discussed below in section 9.4.1.2). This illustrates the interrelationship between the contextual factors, for example adequate support at the training level, provided by the organizational level, could possibly overcome initial resistance at the individual level.

The importance of all three contextual levels (organisational, training and individual) working adequately during OMG transition has been explicitly discussed in more recent literature. WORK-INT (a recent research and advocacy project supporting action-oriented measures

targeting the integration of migrant workers in the health sector at a workplace level)[11] suggested that individual, relational, structural and transnational levels facilitate or impede integration. It was also found that the role of employers and integration into specific organisations is often overlooked, supporting the theory from this thesis that local level support and implementation is important[74]. A study funded by the GMC, looking at fairness in postgraduate training, highlighted the importance of bias in recruitment and assessment (organisational), relationships with seniors being crucial to learning (training), and a lack of autonomy about geographical location of work and poor work-life balance (individual)[25]. Many of the theories evident in the programme theory have been found to influence staff performance and worsen working conditions that can lead to unsafe behaviours[299, 300].

9.4.1.2 Importance of individual factors

The literature often ignores the extent to which individual level factors may impact the success of interventions. Organisations need to recognise the influence of these factors, such as identity, towards the learning of new knowledge, skills, and practices[133]. Much of the evidence is at the macro level, rather than micro level[11]. The lack of focus on the individual level means interventions are not currently effective for supporting integration[11]. The realist synthesis presented in Chapter 4 supports this. The synthesis has been published in *Medical Education*[177] (see Appendix 7) and became the focus of the Journal's 'Commentary'[301]. The authors of the commentary very much supported the findings, noting that adjustment to culturally specific norms is not only an outcome of the programme theory, but it is also a major factor driving the transition[301]. This is evident in the refined programme theory.

OMG difficulties are often related to lack of insight about UK practice, culture, and poor communication, rather than a lack of technical skills[10, 295, 301, 302]. However, supervisors can find it hard to identify what causes performance issues with OMGs. OMGs need to adapt to 'rebuild' their competence before they can draw on their skills which will help them thrive in the new workplace. Skills-based induction will therefore only support transition so far as it is only one part of an overarching approach to facilitating transition. Induction is a process in which understanding prior experiences and relating them to new experiences is important to ensure practice shifts over time[303].

Cultural differences in gender roles and gender equality were reported to be more of a challenge for some OMGs in previous studies[304]. This was still evident in this thesis, for example, greeting patients with a hand shake was a problem for some female IMGs as non-essential touching of the opposite sex is not allowed in some cultures. This was identified as

being an issue for some patients and health professionals in the western society[304]. Capacity to change and understanding of these differences was found to be crucial, otherwise it may evoke defensiveness and organisations may be perceived as discriminatory[304]. Interventions can help to facilitate this.

9.4.1.3 Importance of general adjustment for OMG transition

The systematic review by Lineberry *et al*[53] highlighted that previous studies on OMG interventions focused on knowledge and skills. The authors stated that in terms of desired adjustment outcomes, the focus should not only be on performance. OMGs should be more satisfied, better adjusted to life in general, and more committed to the employing organisation. This again supports the need to target all levels to ensure successful transition.

The findings from the realist synthesis also highlighted that few studies have measured job satisfaction or socio-cultural adjustments. Improvements in knowledge and skills were the primary focus (work adjustment). This is evident through the fact that general adjustment had to be removed from the initial theory due to a lack of evidence to support it. However, the notion of general adjustment was evident in the realist evaluation findings. A wide range of desired outcomes from OMG support activities were important during the development of POD[50, 53, 305]. It was important that OMGs not only performed better, but that they were more satisfied, better adjusted to and more committed to the organisation. Difficulties facing Trust Doctors, largely due to their dissatisfaction with the lack of career progression and role identity were a crucial finding in this thesis. Research suggests that a lack of professional development is linked to psychosocial well-being[12]. National and institutional barriers, practical issues and social inequalities were thought to hinder this[12]. The programme theory within this thesis suggests that organisational culture also plays an important role.

General adjustment is particularly important given the findings that doctors who are under GMC investigation for fitness to practice are at risk of substance abuse or committing suicide[306, 307]. There is little research examining the psychological stress facing OMGs, however given the known fact that OMGs are likely to face additional stress and anxiety[10], mental health and wellbeing is an important aspect of OMG transition that should be addressed. The findings from this thesis support research illustrating that doctors who are recipients of bullying and negative communication have increased emotional distress (including stress and depression), decreased motivation, and a desire to leave medicine[151, 300, 308]. This is important to note since there is increasing recognition that this kind of adverse

staff interaction leads to worse patient outcomes and can represent a patient safety threat[6, 309, 310].

Investment in developing trainee-trainer relationships at work, ongoing support, and the proposed organisational changes (evident in POD) should therefore encourage OMGs to seek social support outside of work[25]. However, this can be a difficult process for OMGs. Many OMG communities are based around ethnicity, culture and faith. It could take over a year to find somewhere where they feel they were welcome, further hindered by rural locations which are likely to be less culturally diverse[151]. The process is also restricted by a lack of social space and resources. As a result, some OMGs are completely isolated[305] (supporting the programme theory).

9.4.2 Implication of findings for theoretical literature

The notion that OMGs must be supported adequately in their transition is evident within the literature, however this thesis extends this knowledge through the development of theory. Previous research has highlighted the need to develop both empirically and theoretically informed ways of understanding interventions for OMGs[53, 102]. Development of theory would facilitate a broader consideration of the diversity of individual OMGs, educational and medical contexts, interventions and outcomes[10, 53]. The developed programme theory does this by exploring how and why interventions successfully facilitate learning, transfer to practice and overall transition. This is the first known piece of research to explore interventions for OMGs in this way.

9.4.2.1 Supporting the grand and middle-range theories

Grand theories were important for developing initial middle-range theories in Chapter 3 and directing data collection during Chapter 4. The Transfer of Training model formed the basis of the developed programme theory[145]. The model was a good fit with other literature exploring OMG transition, as transition is viewed in itself as a process of learning, developing and becoming[311]. The findings from this thesis support, as well as expand on, Kirwan & Birchell's model explaining the transfer of learning to practice. The main concepts include Learner Readiness, Learning Transfer and Organisational Alignment[145], which are thought to impact on performance. Although the Transfer of Learning models helped with initial theory development, gaps specific to OMG transition had to be filled and they did not emphasise that a successful intervention in one context may not work in another context. The complexity of OMG training and transitional issues were instead explored through CMO configurations within this thesis. The configurations are useful in informing intervention

development (explored in section 9.4.3) as they explore what contextual factors are needed to activate the mechanisms that have been identified as leading to desired outcomes. This process is often missed in the literature. This process was important in increasing understanding about OMG transition; the theory has evidently evolved since that posited in Chapter 3.

9.4.2.2 Focus on ongoing support and development of social networks

The developed programme theory within this thesis places emphasis on the need for ongoing support and social networks during OMG transition. It is suggested that this is one of the main reasons why local level intervention was most successful in the evaluation. The small groups of OMGs that attended POD facilitated social learning. It was also suggested that social learning must take place back in practice. OMGs must develop social networks with both UK graduates and OMGs, otherwise this may hinder their cultural adjustment (both to the UK and NHS practice.

The Situational Learning Theory very much supports many aspects of the programme theory in this thesis[137]. The model illustrates that learning through a social network is important for 'community spirit' (sense of belonging and identity). Like POD, this may involve discussions, mutual support and information sharing. Individuals are also self-generating (without external cause), self-selecting and motivated. Both the programme theory in this thesis and Wenger illustrated the need for a repertoire of resources and knowledge that is likely to lead to an enriched learning experience as people are exposed to new ways of thinking and problem solving (linked to Cultural Health Capital and transformative learning). The model encourages a move away from a deficit model of education/professional development and instead encourages appreciative inquiry of existing skill levels, which is important for OMGs to maintain their role identity. Personal relationships, role-models and face-to-face contact are also crucial in the Situational Learning model; increasing adaptability, trust and confidence that is not always available in formal structures. Meaning making activities and 'reflection–in-action'[312] are more likely to facilitate learning than individual acquisition of knowledge and skills (supporting the programme theory). If the working environment allows and encourages the social learning experience, opportunities for professional and practice development are increased, transcending all levels within a work environment (buddying during POD seemed to work better as a supportive culture increased). The intervention can change the conditions that made them work in the first place[1]. If the environment does not allow this type of learning experience, a change in organisational culture is needed.

9.4.2.3 Organisational culture

In order to facilitate OMG transition into the NHS, this thesis has argued that an open and supportive culture is necessary, rather than just engagement with available resources. However, where such a culture is lacking, developing one is likely to be a difficult task. Culture (including values, symbols, behaviours, and assumptions) is generally learned through organisational experience and habit. This therefore makes it difficult to unlearn when "the way we do things around here" is already set[313].

OMGs must also learn to display the relevant norms, values and behaviours, so that they become an accepted member of that culture[302]. OMG development and identity formation may be hindered by the lack of a supportive culture. Some doctors may not be accepted if they do not fit prototypes. A feeling of not belonging and having to make identity shifts can be very difficult. This may become problematic and lead to behaviours perceived as 'unprofessional'. Social and professional identity must therefore be made explicit to help to avoid identity dissonance or role-conflict. Training level must take responsibility, as well as the individual, to ensure cultural competency.

The thesis illustrated that some staff, including OMGs, accepted that support was limited in their organisation due to strains caused by staff shortages, high workload and many other stresses. This is not necessarily specific to OMG support, dissatisfaction amongst post graduate training being at an all time high[314]. However, a high number of OMGs are likely to work in those places deemed to be less popular and therefore the organisation is likely to be facing difficulties that will hinder a high level of support. As the programme theory suggests, although key figures may highlight that change is needed, colleagues and supervisors in such organisations may not be receptive to the idea of culture change and local implementation. Culture change may also be harder in organisations where there are a lower number of OMGs. Support from higher levels may help with resistance (discussed next).

9.4.3 Implication of findings for policy and practice

The programme theory presented in this thesis illustrates why interventions work (or not) and in what ways, thereby enabling those implementing interventions to make more informed choices. Key facilitators and barriers have been highlighted to guide development. The potential benefits of well-developed interventions for OMGs, their employing organisation, the NHS, and ultimately patients, have also been highlighted.

9.4.3.1 Using the programme theory to guide interventions

Although OMGs need to take responsibility for their learning[304], the findings in this thesis highlight that local, regional and national levels also have responsibilities. As evidenced in this thesis, OMGs transitional needs are complex and can go unnoticed, therefore organisations need to be proactive in their support system, moving beyond competency training. This thesis provides recommendations for local level implementation (see section 9.5). Obviously, the evaluation of POD is context dependent, but the programme theory enables consideration of factors that were found to impact intervention success and how desired outcomes could be facilitated. Organisations can also use the programme theory to evaluate what they do within their organisation (setting a level of expectation) and understand why they may be facing difficulty in supporting OMGs to a successful transition. As is evident in the findings of this thesis, evaluation is very much lacking. Successful outcomes may also lead to increased engagement and enthusiasm towards the interventions from all levels.

Discussions with experts highlighted that the training level has perhaps been devalued for some, supervisors and trainers needing to take responsibility. With workload pressures increasing, it is more important than ever to safeguard educational activities. The GMC training survey[315] highlighted that trainers felt they did not have adequate time in their job plan to fulfil their roles and patient safety issues were a concern.

The importance of regional input and sharing of best practice is emphasised in the thesis. It is suggested that key changes to current levels of OMG support and interventions need to be driven and overseen from regional bodies. Many Trusts now work in silo, therefore regional support and guidance is needed (recommendations given in section 9.5). This would also help to signpost Trusts to readily available resources.

Policy makers from a national level could ensure standards are set for OMG support (recommendations in section 9.5). Regulating bodies could also help to identify and recruit OMGs for the interventions. However, discussions with the GMC highlighted that they feared creating a sense of stigma by targeting OMGs in this way. Given that the GMC has commissioned research highlighting the need to support OMGs better[316], this should be reconsidered. It should also be noted that OMGs have highlighted in the evaluation findings that they would appreciate the extra support. Mandatory interventions would be beneficial, particularly at the local level, however support from the GMC would also be needed for this to happen in all Trusts (help to overcome barriers created by workload and resources).

9.4.3.2 Assumptions concerning OMG practice

The term Overseas Medical Graduate was used in this thesis to encompass both European and International Medical Graduates (IMGs). However, differences between the two groups were evident in this work. The interview data suggested that European graduates struggled more with communication and were more likely to have reduced self-awareness. This may be explained by the graduates' assumption that they were from a similar culture and had trained in a similar healthcare system to the UK. Assumptions were facilitated further by the lack of examinations prior to entering UK practice (ease of access may change following UK exit from the EU). Supervisors or peers may hold similar assumptions and therefore fail to offer adequate support. This may hinder the individuals' awareness further. The above explanations may also explain why the GMC found that European graduates were more likely than UK graduates to be referred for fitness to practice allegation[28]. It may therefore be beneficial for regulating bodies to consider further revising how European graduates are assessed prior to obtaining posts. This research has hopefully increased insight into EEA graduate transition and highlighted important concepts to consider, which was noted as lacking in the literature[17].

IMGs may have better communication skills since many overseas medical schools teach in English. An interesting finding in a report recently commissioned by the GMC found that IMGs who excelled in speaking tests were more likely to face sanctions as a result of their practice[317]. One proposed explanation is that where language is better, the individual may be better at talking their way out of difficulties in practice and therefore left unsupported. Colleagues may assume that given their language skills, their clinical performance may be of the same standard. It is of further interest to note that few of the sanctions were related solely to clinical skills, instead they were related to professional behaviours. Language and culture are hard to separate, for example more senior OMGs who speak fluent English may have been practicing within their culture for many years. It was also found that IMGs who excelled in their language test were likely to be at the average performance level of UK graduates[32]. Competencies should therefore not be assumed; individuals must be assessed.

9.4.3.3 Utilising OMG skills efficiently to overcome current strain on the NHS

Retention is currently an issue for the NHS. Many organisations are rely on, and actively recruit OMGs to fill staff shortages[95]. Locums and Trust Doctors are utilised a great deal within the NHS, and have been for a long time, however they are identified as the groups most at risk of facing challenges. This is likely to be due to a lack of support and training. In

comparison, doctors in training largely perceive their work environment to be supportive[315]. The way in which doctors in non-training posts are regulated and monitored also varies. This thesis attempts to illustrate how investment in ongoing support for OMGs can be an asset for their performance, retention and career progression. Instead of being used to fill gaps, OMG skills should be utilised so that both OMGs and their employing organisation benefit.

Regulatory bodies still do not fully understand why OMGs are over-represented in fitness to practice or why they may be more likely to fail during training[35]. This thesis presents possible explanations and helps to raise awareness about how organisations can implement interventions to successfully support the transition of OMGs into the NHS.

9.5 Recommendations for policy and practice

This thesis has demonstrated the value of ongoing support for OMGs. Interventions may prove difficult to implement for several reasons explored within the programme theory, however the NHS and regulating bodies should aim to tackle these challenges if they are to fully benefit from the contribution of OMG doctors here. Recommendations are presented below.

- ***National policy***:
- Help to improve practical barriers identified at the organisational level, such as monitoring and recruitment of OMGs.
- Set standards and provide guidelines for regional and local levels.
- Ensure ongoing monitoring of transitional outcomes and best practice.

➢ ***Regional programme & policy:***

- Implement **regional induction for overseas doctors.**
    - *Key information and resources - GMC/culture/NHS structure/careers etc.*
- **Educate key stakeholders** in each Trust (directors/educators/programme leads etc.).
- Produce a **set of guidelines** for local level implementation, including;
    - *Recommendations for interventions and bank of resources*
    - *Enhanced supervisor training*
    - *Buddy/mentor system (based on individual needs)*
    - *Working group involving both supervisors and overseas medical graduates*
    - *Clear expectations document for OMGs*
    - *Local information about the community*
- Help struggling Trusts with **resources** needed for implementation locally if needed.
- **Disseminate information to OMGs** (eLearning and bank of resources).

➢ ***Local level implementation of programme for overseas doctors:***

Organisational level

- Increase cultural awareness and facilitate the development of a supportive culture.
- Identify key figure to monitor interventions.
- Establish links with HR to identify ALL incoming OMGs (particularly Trust Doctors).

Training level

- Implement a Programme for Overseas Doctors:
    - *Spread across several weeks/ use of internal resources/ needs assessment*
    - *Include communication skills training (role-play), NHS structure, ethics, culture, careers etc.*
- Support system needs to be in place back in practice both formally and informally e.g. *buddying system, enhanced supervision, development of orientation, social.*
- Implement a Trust Doctor tutor (identify one person to monitor).

Individual level

- Individual needs assessment should be conducted (PDP, competencies etc.).
- Expectations set prior to applying for job role.
- Ensure all doctors have access to portfolio/training (including non-training posts).

9.6 Use of the realist approach within this thesis

The realist approach used in this PhD was the most appropriate given the research aim. The accumulation of knowledge is related to our understanding of the behaviour of mechanisms in certain contexts and how and why this interaction of context and mechanism causes certain outcomes. As discussed in this chapter, the approach not only led to a developed programme theory that explored how interventions can successfully support OMG transition, but also educated stakeholders about the importance of the evaluation process (evident in the POD planning team). Given that this is a relatively new approach within medical education, it is important to explore its use within this thesis and hopefully educate researchers by highlighting strengths and weaknesses.

9.6.1 Applicability of the programme theory

The realist evaluation approach used, by its nature and epistemological stance, was specific to the main organisation in which it was undertaken (AH). Although generalisations cannot be made from single evaluation studies, particularly due to subjectivity, it is believed that the programme theory within this thesis is transferable in terms of underlying patterns and principles required for intervention success in other organisations (knowledge of the real world)[122]. The focus on context within this thesis was seen as a strength, rather than a weakness. As Pawson and Tilley state, "Be unafraid to ask big questions of small interventions and to use small interventions to test big theories" (p.322)[318]. The evaluation built upon previous research and relevant scholarly areas applicable to OMG transition, many of the mechanisms having undergone previous testing. A rigorous process, both deductive and inductive, was undertaken to develop and refine the initial middle-range theories. Both primary (realist evaluation) and secondary data (realist synthesis) were used. The primary data was collected using different population samples within the intervention site (using two different cohorts across two years) and comparator case sites, to test the emerging theory. Triangulation of all the evidence, including experts from external organisations, meant judgement could be made and patterns in the findings can be used (with caution) when supporting OMG transition in other contexts[319].

Contextual conditions that were important in supporting OMG transition most efficiently were focused on when presenting the theory. This ensured the theory was practitioner friendly and met the expectations of the key stakeholder. In the write up of the findings within this thesis, CMO configurations are clearly labelled within the text. This is to make the

configurations obvious to the reader, whilst also helping to educate readers about the realist approach.

9.6.2 Conducting the realist study

At the time of this PhD there were no clear guidelines for conducting a realist evaluation, however subsequently guidelines on reporting were developed[105]. The lack of boundaries was not viewed as a negative thing, allowing for creativity in the theorising process. A 'realist interview' seems to be the most common way of testing programme theories during interviews, however it was decided that the programme theory would only be presented to participants at the last data collection point (with experts). The programme was still thoroughly explored, however it was not explicitly presented (it being anticipated that OMGs may not challenge the theory). The realist approach by nature involves iteratively testing theory using a large amount of evidence. This thesis was rigorous in its approach, in conducting both a realist synthesis followed by a thorough realist evaluation. The novel design of the study, with the use of comparator groups, was effective in ensuring the research aims were met. These findings also proved to be of great interest to key stakeholders.

The complexity of the CMOcs meant that the process of analysis was not straight forward, particularly during the realist synthesis, where the framework was still developing. However, difficulty was avoided using memo writing. Memos were important for keeping CMO links clear and to record the developing and emerging theory. Linking performance outcomes to mechanisms was also quite difficult during the evaluation, this link sometimes having to be inferred from the other data collection. However, because a framework was used to guide data collection and analysis, the process was made easier.

9.6.3 Limitations of the realist approach within this PhD

As discussed in the previous section, there is no simple formula or guidance for conducting a realist study. The research required sustained thinking to work through the large quantity of data and to develop an overarching theory. The focus was on importance, rather than frequency. However, it was difficult to decide when saturation had been reached and when enough detail to the theory had been added. This was particularly evident in the realist synthesis, where focus was initially lost through identifying too many grand theories. This meant both the initial theory and data collection lost focus. However, this was overcome by further learning about how to develop focussed theory following attendance at realist conferences, learning through experience, and discussions with experts and stakeholders.

The complexity of the developed programme is evident through the 'cog' illustrations (with lots of cross over and lines), also highlighting the relationship between the three levels. The thesis does highlight when there is also cross over between the levels, however it does not fully explore this. This would have created even more complexity in the development process.

There were instances during the realist synthesis where it was difficult to decide whether the data should be termed a context or a mechanism. Similarly, what was a mechanism in the developing theory was sometimes labelled an outcome in the paper. The difficulty in deciding where aspects of data fit in the model highlights subjectivity in the theory development process as a limitation. However, ongoing discussions with the supervisory team and experts meant that this was largely overcome. It was also ensured that application of data to the theory was justified and transparent. Most of the papers reviewed failed to give specific examples of process and this made developing theory quite difficult. It was understood that this was the complex nature of the realist approach and led to the accumulation of knowledge; the core of realism being to unpack the black box[6, 113, 183]. Mechanisms did not need to be clearly evidenced to test and observe regular patterns.

Outcomes were also missing from the literature, largely due to a lack of empirical data or the inclusion of descriptive pieces. This meant inferences were often necessary. During the realist evaluation, making clear links to the outcome data was not an easy task as the data was collected separately. The links were explored through interviews, however, links also had to be inferred as the cause was not empirically tested. The lack of clear links between the CMOs highlights the important role of initial theory guiding data collection. Unlike most empirical studies, focus of the study was towards programme theory not intervention[115]. The purpose of the data collection was therefore to test the proposed theories: different aspects of the theory were tested separately. However, this could have caused issues with 'over-fitting' the data the theory, the proposed patterns possibly not explaining the underlying reality that caused them[115]. There may have been other factors affecting outcomes in addition to the hypothesised CMOs. A conscious effort was made to avoid this during data collection and analysis. It was the purpose of the realist evaluation to validate the theory, which also included shedding light on aspects of the theory that may not fit well or aspects that were not evident in the framework. Original transcripts were therefore checked following theory development, specifically to identify themes which challenged the programme theory.

Ensuring transparency to combat the subjectivity issue throughout the whole study is important in realist evaluation. An audit trail was clearly documented, however documenting all decisions became more challenging due to the large amount of data from different sources, including discussions outside of interviews. Exact replication of findings is unlikely, in fact replication is an inappropriate concept for realist evaluation[5]. Empirical generalisation was not intended. All data, even thoughts, were coded in NVivo and Excel to minimise issues and make the process more robust.

9.7 Overall strengths of the study

This research has an explicit focus on the process involved in the development and implementation of interventions to support OMG transition. The evaluation of the Programme for Overseas Doctors (POD) enabled the development of theory and provided a detailed picture of the process. A range of practical, logistical and theoretical issues are highlighted.

Many of the strengths of this thesis are due to the in depth realist approach used (see section 9.6 for strengths). This is the first known piece of research to explore the theory of OMG interventions. The theory was tested and refined on many occasions, through several cycles of data collection, and was validated by experts. This may explain why emergent theories were minimal. Challenges to the theory were sought, however, the theories were largely supported by the data, or led to refinement. As a result, it is likely that theoretical level of data saturation was achieved.

This realist approach has helped to fill many of the gaps identified in the literature, adding to understanding about the complexity of interventions for OMGs and their transition[53]. The research therefore adds to both empirical and theoretical literature (discussed earlier in this chapter), helping to connect to broader bodies of research and practice[53]. The research also has implications for policy and practice. The impact of the findings is discussed in section 9.11. The thesis also adds to the ever-growing realist methodology literature, clearly illustrating the processes taken in theory development.

The mixed methods used enabled all aspects of the programme theory to be explored. The interviews were the main data set presented in the thesis, which included multiple perspectives collected over multiple time points. This was an extensive data set, including over 100 interviews with OMGs, their supervisors, 'buddies' and comparator groups, over a two year period. Previous studies have looked at perceptions of either OMGs or those

working with them; this research does both[304]. The comparator groups add a unique layer to the research, helping to refine the theory by exploring what barriers were in place that may have hindered intervention success and overall OMG transition. Although a low response rate of comparator OMGs is evident, their participation in the study was to explore issues, particularly barriers, and refine the theory.

There was a very high response rate from OMGs that attended POD, supervisors and 'buddies', there being very few from the population samples that could not participate. The participants were also varied in terms of specialty, training level or post, gender and country of qualification. The high response rates from supervisors ensured that at least one supervisor for each OMG was interviewed.

9.8 Overall limitations of the study

The limitations of using a realist approach were discussed in section 9.6.3. The complexity of OMG transition, the intervention and the realist methodology caused some initial challenges. It is important to note that the research design used in this thesis added to this complexity. As a result, some of the identified contextual levels had sub-levels within them, for example, the context of the intervention versus the context after the intervention was implemented or context of those taking part in the intervention versus those who did not receive an intervention. It also suggested that the formulation CIMO (Context, Intervention, Mechanism, Outcome) may be more useful when developing configurations than simply CMO. Without the intervention component in the configuration, presentation of findings became complicated during the realist synthesis when the focus was not on one single intervention. The same was apparent in the realist evaluation, POD being made up of several components. The non-intervention group complicated this further. Research has begun to look at the development of methodology[4, 124].

The realist evaluation may also be criticised for the small sample sizes within each group, particularly as OMGs completed pre- and post- intervention questionnaires. However, these represented entire population samples based on OMGs that attended POD. It should also be noted that the mixed method design was to ensure all aspects of the programme theory could be explored. The questionnaires were therefore not the focus of the research findings, but intended to give some extra insight into context and mechanisms. They identified trends which could be explored further.

The comparator groups were also small samples, but again this was due to the nature of the

research. Population samples of this group were not sought as participants were recruited to complement the research and test aspects of the programme theory. Initially, POD was supposed to be implemented in comparator sites, however this did not happen (discussed in Chapter 6). The design of the evaluation therefore changed, however looking at barriers to implementation and resulting transitional needs proved beneficial. It is also important to consider that OMGs from these Trusts may have been more willing to take part in the research if they had faced negative experiences. Other OMGs volunteered to take part through the HEENE interventions, therefore this may highlight something about their personalities, or perceived lack of support. Despite this being seen as a possible limitation, similar themes to the intervention group were apparent and proved important in terms of theory refinement.

Questionnaires given during POD used self-report measures, therefore were reliant on OMGs being honest and having insight about their transition. Self-report measures have been criticised for subjectivity[320], however given that individual factors were an important aspect of the programme theory, these questionnaires explored important perceptions of the OMGs. The focus was not on outcomes of the intervention, the programme theory looking beyond that in terms of OMG transition. Interviews were used to collect retrospective data across one year, therefore explored the impact of the intervention on their practice. Triangulation of sources, including supervisors, helped to overcome the issue of self-reporting measures.

It is also possible that all of those involved with POD may have had a strong inclination for it to be a success and therefore may have had positive bias. Likewise, where negative experiences were faced, the participants may have been overly critical. The research design, particularly the triangulation of sources and data, helped to overcome such issues. Again it is important to remember that the focus was on assessing theory and processes, not the intervention outcome.

There was also the possibility of confirmation bias[278], particularly with OMGs where culture may mean that they do not want to disagree with the researcher. They may also fear disclosing certain information. However, as discussed in Chapter 5, steps were taken to overcome such issues (e.g. ethical procedures, role of researcher). Confirmation bias was also addressed by the fact that clear examples were asked for during interviews to ensure participants did agree, or disagree[278]. Also, other than experts at the end of cohort 2, participants were not asked directly if they agreed with the programme theory. Instead

specific aspects were discussed and explored. Advice from realist experts was also received. Discussing rival CMOs also ensured any confirmation bias was minimised.

Finally, one factor that was highlighted through interviews with supervisors was that AH was perceived to be a high reporting Trust (all incidents and everybody involved were put on the system so that reporting became the normality). This suggests that performance data collected through the Educational Governance (EG) system is Trust specific. It became evident in the findings that reporting of incidents against OMGs may not be related to their actual performance, but could be related to other factors (for example discrimination or educational purposes at AH). Therefore, the EG data was used with caution when exploring the theory. As mentioned throughout, the design of the research meant that outcomes could be explored in other ways and so could help to infer causality.

9.9 Personal reflection

When I started this research project, I did not have a great deal of knowledge about postgraduate medical education. I found that it was extremely important for me keep up to date with medical education, policy and politics. I also attended some educator working groups to understand current issues of focus. Ever changing decisions impacted on both research needs and findings. An example of this was the decision for the UK to leave the EU and the establishment of the new junior contract. The impact of these issues on OMG transition was evident towards the end of my PhD.

The importance of networking and conferences was also evident throughout my PhD. Following dissemination of my work, individuals from regulatory bodies and individual Trusts were contacting me to discuss the findings. Many of these individuals became involved in recruitment for this research or were recruited themselves as experts. Discussions helped to validate and refine key messages. Concerns were also raised about the current state of postgraduate training and support. It was interesting to see that educators and regulators were aware of the lack of support for OMGs, particularly Trust Doctors, yet it was still an ongoing issue. Barriers to implementation were highlighted, however it is hoped my thesis can shed light on possible solutions. I was able to give real life examples from my research about consequences of a lack of support for OMGs, which seemed to have a major impact on both emotions and attitudes. The positive reactions towards my recommendations were important for both my research and my confidence in my PhD. I was able to engage and advise on other interventions taking place, which gave me further motivation and passion for the subject. Challenges to the theory were also sought. I have discussed the development

of theory and findings with scholars from several countries, including Canada, Spain, Italy, Australia, New Zealand, Germany, India and America and of course the UK. These scholars live and work in varying healthcare systems and contexts, yet the issues presented in this thesis were very similar.

My role as an external researcher at the funding Trust was important as I was not influenced or predisposed by prior involvement. This meant I could conduct the research in an unbiased manner. I was very engaged with the educators and intervention planning team across the three-year period, which proved to be beneficial in terms of their engagement with my research, recommendations and my ability to express any concerns to them. It also meant I was involved in all aspects of the intervention development. It was a concern to me that the intervention planning team would not be as engaged with the intervention once my research had finished. However, sustainability of the intervention will likely take place as key figures have been appointed to oversee the continual development and implementation.

The realist approach has been a challenging yet rewarding process. One worry towards the end of the evaluation was whether I was directing the line of questioning to challenge the theory enough. I therefore not only checked the transcripts again to ensure I did not miss anything, but I consciously tried to discuss alternative theories with the 'expert' group. I therefore saw the fact that there were minimal challenges to the programme theory as a positive. Initial challenges I faced were those discussed earlier in this chapter concerning the use of the realist approach. However, having a publication accepted in the Medical Education journal helped me to clarify my theory and present my work in a more meaningful manner. Feedback from the reviewers raised important questions that I needed to consider.

In working on another realist project outside of my PhD, I saw how far I had come in terms of understanding the realist methodology. I was able to support the team's learning about the realist approach and gave them advice on the process. Relevance and rigour were often debated, however my feeling is that relevance is more important than rigour in the realist approach. As an example, descriptive papers in my study provided rich and insightful information explaining the context and mechanisms, often inferring an outcome.

Theorising became the core component of my PhD, based upon my engagement with both literature and data collection. Theoretical approaches are important in medical education so that processes can be understood. I do, however, recognise that theories will always be questioned in terms of their reliability, and validity. The use of mixed methods in this thesis,

including outcome data, was beneficial in helping to address this and to explore the programme theory.

9.10 Recommendations for future research

Testing of the programme theory:

This is the first known piece of research that has evaluated interventions for overseas doctors using a theoretical approach. Therefore, more research is needed to develop and test the proposed theory. Comparison sites were used to support theory refinement however research now needs to test the theory fully in other Trusts and using other interventions targeting overseas doctors, in the UK and overseas. It may be useful to explore the programme theory with interventions in other countries as the literature illustrates that interventions for overseas doctors are already established in some nations such as Canada and Australia[321]. It would be beneficial to study well established international interventions to investigate how they work, how they are sustained, and whether they can feed into the programme theory developed in this thesis.

The comparator sites where the programme theory refinement took place were known to be disadvantaged in terms of resources, demand for job roles, and location. It would be beneficial to further test the programme theory in a wider variety of Trust sites with different contexts such as resources, cultures and awareness to determine the effectiveness of the theory.

POD was made up of several components including induction sessions and buddying, therefore it was not clear what aspects of the intervention were most effective as they were not evaluated separately. Although the programme theory suggests all elements support OMG transition, future research could consider these elements separately.

Other health professions:

One of the key possibilities for further research resulting from this thesis would be its applicability for other health professionals. Theoretically the core principles of the programme theory could be applied to any educational intervention, therefore it could be beneficial to apply this theory to interventions for nurses looking to come to the UK from overseas. The realist synthesis presented in Chapter 4 has already engaged with this avenue of research as it looked at all medical graduates, not just doctors, however further refinement and research is needed. This research would be important as the NHS is recruiting large numbers of international nurses who may need the support identified within this work.

A group of graduates that is largely missing from the research into OMGs are those born in the UK who obtain their medical degree overseas. The successes and failures of their transition should be examined in order to ensure they are fully integrated into UK practice. It is unknown whether they need the same level of transitional support as OMGs.

Exploration of outcomes:

This thesis looked at the inferred outcomes for patients treated by OMGs through performance data. The literature and the programme theory would benefit from assessing the real outcomes and experiences of patients and how interventions for OMGs have affected the patient experience. This line of research would require patient feedback on their perspectives, views and experience. By pursuing this line of research the effectiveness of the interventions, and therefore the benefits of the intervention can be explained to stakeholders, Trusts, and the public.

There should be a further study into outcomes such as retention rates, job satisfaction, performance, and career progression. The Educational Governance data analysed in the realist evaluation was only an indication of OMG performance and therefore links have not been empirically explored. Future research could provide more evidence to illustrate any changes in outcomes during the ongoing period of transition.

Evaluation tools for organisations:

OMGs, particularly IMGs, face a great deal of assessment before entering UK practice. However, the individual factors presented in the programme theory could be explored by organisations at the recruitment stage, for example expectations and preparedness for practice. Further research should be conducted to develop such tools based on the programme theory to help assess their transitional needs. The purpose of this would be to ease their transition further.

A questionnaire could also be developed to evaluate transition success of overseas doctors. Both the OMGs and supervisors should be involved in the sample as this will give a more comprehensive assessment. Research on this line would be beneficial to all parties including the GMC who should know how well OMGs are transitioning into the NHS and also how successful interventions are.

Longitudinal study:

In order to look at the long-term impact of the intervention, a longitudinal study could also be conducted. It may also be of interest to provide a follow up of OMGs who have left UK

practice, specifically those who did not partake in an intervention. It could further explore why OMGs leave and whether their experiences in the UK informed their practice back in their own country. For those who left and partook in an intervention, it should be ascertained whether the intervention had a positive impact on their performance and abilities as a doctor.

9.11 Impact of findings to date

Dissemination of the PhD findings has largely been through conference presentations, discussions and invitations to present at individual organisations. Discussions and feedback further helped to validate the programme theory. The findings have impacted current practice and policy in several ways; locally, regionally, nationally and potentially internationally (presented below). This will help to further test the programme theory in the future.

9.11.1 Impact of findings – POD (AH)

POD intervention:

The evaluation resulted in the development of a successful intervention (POD) at AH, that is now mandatory for all OMGs new to UK practice to attend. POD has changed substantially since the first pilot developed in 2013. Cost of implementation was massively reduced because of the findings. Evaluation and momentum for POD has been sustained to date. The Trust Doctor Tutor now oversees the running of POD, which works well as most of the doctors likely to attend will be under his supervision. POD is recognised nationally as an example of good practice. The evaluation findings have been used to develop other interventions regionally, nationally and internationally.

***Trust Doctor Database*:**

A new database was introduced for Trust Doctors to help with tutor appraisals, portfolios and one to one meetings. Previously, Trust Doctors who were difficult to identify, meaning that they were not effectively monitored on the educational system. A similar database for Staff and Specialty (SAS) grade doctors was used at AH. Advantages included easy identification regardless of job title and monitoring of training needs.

9.11.2 Impact of findings – Regionally (North East)

Directors of Medical Education (DME) meeting:

A meeting at HEENE with DMEs in 2016 was attended and research findings presented. All of those in attendance were highly engaged with the findings and the Postgraduate Dean suggested a future collaboration for regional development. Attendees were not shocked by the evidence illustrating that many OMGs faced negative experiences in their transition, but they were disappointed. No responsibility had yet been taken to address such issues. Discussions highlighted that interventions were lacking, however concerns were raised about workload. All attendees were told to go back to their Trusts and reassess what support was in place for their OMGs. Ensuring OMGs were supported was important given that the North East intended to rely on OMGs to overcome staff shortages. Organisational and training factors were identified as factors that HEENE could try and take responsibility for.

North East Programme for Overseas Doctors (NEPOD):

Following the findings from this PhD, HEENE recognised that their OMG induction needed development as it lacked appreciation of the identified contextual factors (both during and following an induction programme). In September 2016, HEENE refined their induction to reflect these findings. OMGs that attended HEENE inductions previously were invited to share their experiences. Individual level factors were discussed with OMGs to help to recognise and address potential issues that could hinder their transition.

Facilitating local level implementation:

The attitude from HEENE towards local level interventions for OMGs changed following the success of POD. HEENE recognised that regional interventions are limited and that they therefore need to engage with individual Trusts to develop interventions themselves. As an example, Specialty Training vacancies were identified in the region and Trusts planned to fill these posts with OMGs recruited through a Medical Training Initiative (MTI). HEENE advised that all candidates would need a period of induction and assessment of competency. POD was identified as a requirement for them. HEENE also planned to engage with Trust recruitment pathways to arrange and facilitate recruitment for local inductions and buddying systems. Ongoing support was provided for both trainees and trainers via resources on their new website. A handbook of information has also been developed for Trusts to give out. Evidently, a much needed increase in support was recognised. Although interventions could not be mandated for all groups of OMGs, HEENE planned to engage with key stakeholders to

guide implementation and disseminate information about interventions as much as possible. HEENE would also supply resources as much as possible.

'Train the trainer':

A workshop for those responsible for the training and support of OMGs has been organised for February 2017 to ensure organisations recognise the level of support and commitment needed. Recommendations targeting organisational, training and individual levels will be given; advising how to implement interventions like POD. Focus will be on creating a supportive and open culture in each hospital, induction content, buddying and enhanced supervision. It may not be possible for interventions to be developed in the same way, but core elements should be in place. Medical leads, Education leads and HR/admin leads from each Trust will discuss plans of how the region, and HEENE, can better support OMGs in the future. Other Trusts and schools have recently been developing similar schemes and therefore sharing examples of good practice is also important. High attendance is expected at the event.

Refugee Programme for Overseas Doctors (REPOD):

A collaboration between HEENE and AH led to the development of their Refugee Programme, which began in January 2017. Development and implementation of the intervention was largely based on the findings from this PhD and AH expertise in supporting OMG transition, however taking into consideration the extra training and support needs that refugee doctors would need. The intervention involved three phases; supporting them passing their exams, providing voluntary clinical tutors and facilitating voluntary work (non-clinical) and supporting them into clinical attachments. Ongoing clinical mentors were provided and support would be given in securing jobs. Evaluation of REPOD will take place on the same way as POD; testing of the programme theory within a different context.

9.11.3 Impact of findings – Nationally

Royal colleges:

Deans from Royal Colleges (General Practice and Psychiatry) were looking for an evidence-based approach to the issue and therefore have used the findings from this research to develop their interventions (sought through email following conferences and recent publication).

Trusts throughout the UK:

A high number of Trusts and organisations within the North East, as well as outside of the North East, have enquired about the research findings and sought to understand how they can both implement or develop their current support system for OMGs. Following many meetings, discussions, and these PhD findings, a number of Trusts have recognised that they are not implementing an efficient programme in tackling all the needs of OMGs. Focus was on the lack of an ongoing support programme or their failure to include any experiential learning opportunities. Trusts have therefore used the programme theory to adapt POD to suit the needs of each hospital and OMGs.

The National Association of Clinical Tutors (NACT) UK:

The National Association for Clinical Tutors (NACT) UK sent an invitation for these PhD findings to be presented and discussed at their recent National Multi-Specialty Meeting in January 2017 (attendees included Postgraduate Deans, Medical Directors, Education Directors, Training Programme Directors, GMC etc.). As a result, NACT UK plans to develop guidelines to overcome the current range of support offered to OMGs throughout the UK. Like HEENE, NACT too recognised that responsibility is mainly at the local level to implement interventions like POD. Directors of Medical Education therefore need to promote the guidance within their Trust. NACT delegates felt that all levels of seniority were aware of the problem, and despite some efforts being made, most had been ignoring the full extent of the issue. The lack of support and lack of training opportunities for Trust Doctors were thought to be the main factor causing the problems identified. Due to the current staff crisis that the NHS faces, NACT felt the findings of this PhD were important to feed into their future plans to increase retention of OMGs. Attendees planned to go back to their Trusts and tackle the issue following the recommendations made.

Development of a toolkit for trainers of those in non-training grade posts; Health Education England (HEE):

Educators at Health Education England East Midlands took charge of developing and evaluating a toolkit for trainers of those in non-training posts. HEEEM sought guidance following the research findings of this PhD as they saw the importance of the three contextual levels in the design, development and implementation of the intervention. They felt this approach would ensure best practice. Collaboration is currently taking place during the development and implementation stages. The toolkit will include advice for Trusts in the region about how to implement interventions for those in non-training posts; targeting both clinical directors and trainers. An online toolkit will also be developed. This will advise all

levels identified from this research of their role in ensuring doctors in non-training posts are supported efficiently (including Deans, supervisors and colleagues). POD will be used as a key case study to demonstrate success. Evaluation will then take place, further testing the programme theory.

Interest from the GMC:

Research findings have been presented to the GMC (individuals included education and policy makers, PLAB exam coordinator, Head of Diversity, and individuals who lead current OMG interventions). Ongoing discussions are taking place regarding developing their current Welcome to UK Practice induction (only 3 hours long) and developing a set of national guidelines. The need for investment in ongoing tailored programmes was recognised. Discussions with the GMC have also highlighted that the current assessment of OMGs (i.e. PLAB, IELTS) may have once been fit for purpose, but now gaps are being seen.

9.11.4 Impact of findings – Internationally

Networking at conferences:

Following the presentation of a research paper in September 2016 at the Association for Medical Education in Europe (AMEE), policy makers and education leads from Germany, Canada and Taiwan requested further information about POD and the programme theory. Individuals from Germany wanted to develop similar guidelines as they lacked any assessment for their OMGs. Individuals from Canada already had support systems in place, but found them difficult to implement. These individuals learnt from the programme theory why interventions may not work in some contexts and how they could address the issues that they faced.

9.12 Conclusions

Aims and challenges:

The aim of this thesis was to explore and evaluate interventions that have been developed to support the transition of overseas medical graduates to the UK. The Programme for Overseas Doctors (POD) has been explored in detail and compared to the measures in place in other Trusts. This work has gone on to further explore the challenges facing overseas doctors, Trusts, and the NHS as a whole in facilitating a successful transition into UK practice. The key challenges are: organisational context, in particular the development of an open and supportive culture; resources and high work load, meaning the availability of the OMG to attend a thorough intervention due to the demands experienced by a very busy ward and amount of investment than can be given to ongoing support; and the individual context, meaning that the transitions are dealing with people and therefore their unique needs and barriers need to be addressed. Despite a great deal of investment needed, key stakeholders should recognise that outcomes will likely outweigh the costs, which is currently important given the likelihood that recruitment of OMGs will increase in coming years.

The realist approach:

The realist approach which was adopted for this piece of research has been shown to be the most appropriate method for intervention evaluation given the complexity of the subject matter. The programme theory helps to understand what processes need to be in place to successfully support OMGs. Although the evaluation was largely context specific to the Trust implementing POD, the patterns (theory) can be used to develop or refine interventions in other contexts.

Reflection of interventions:

Interventions are required to respond to the need to improve OMG employability and productivity in the UK. A successful transition is defined in terms of outcomes relating to adjusting to the new work environment, cultures, interactions, and general adjustment to UK practice. It has been shown that POD was an effective intervention. This was largely due to the consideration given to the organisational and training level. There was buy in from all parties at all levels and there was an open and supportive culture which put training and development at a high priority. The fact that POD acknowledged individual factors by conducting needs assessments and implementing small group learning meant that the intervention addressed the needs of the OMG giving a better basis for successful intervention. The successful implementation of POD has raised awareness in other Trusts

that such interventions may help in increasing performance and retention of their OMGs. Success in these Trusts will be dependent on whether the three contextual levels; organisational, training and individual, are identified and addressed.

The review of POD showed that establishing strong support networks and ensuring overseas doctors feel welcomed and supported is critical to adjustment. This allows a certain amount of resilience to be built up, but this resilience can be damaged in the wrong environment and have a detrimental effect on their transition. OMGs often learn to adapt on their own, but with ongoing support from the organisation, the process can be improved. OMGs need to know what is expected of them to make their transition successful. This highlights the need for good communication from key stakeholders and organisations, to help manage expectations. All parties have a responsibility in this[304].

Importance of research:

OMG transition is vital to the future of the NHS given its reliance on overseas graduates. Despite this importance there has been a substantial literature gap around interventions supporting OMG transition, hence the importance of conducting this research. This work should help increase understanding of the crucial role of contextual factors and allow researchers and organizations to do a better job of supporting the transition of OMGs. A developed understanding of the adjustment process faced by those transitioning to UK practice, as well as the level of resources required to support these individuals has been provided meaning that this thesis can have a direct positive influence on future interventions.

Overall, this thesis builds on OMG literature and extends understanding of interventions to support their transitions. The research explored OMG transition through case studies and provides a basis for stakeholders and scholars to understand the challenges facing all parties in successfully facilitating OMG transition. Support for interventions is starting to build momentum this momentum must be maintained. This work should help to maintain momentum and to create better doctors for the future of the NHS.

Concluding message:

Successful interventions need to be more than a simple one day programme. Interventions must focus on creating a positive open and supporting culture to ensure OMGs fit into the workplace effectively, they must address individual needs, and they must include ongoing support beyond the initial intervention. This thesis has reviewed what was a successful

intervention and has put forward recommendations for future programmes and future research.

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Appendices

Appendix 1: Detailed study characteristics of the papers included in the realist synthesis

Appendix 2: University ethics approval for service evaluation

Appendix 3: University ethics approval for full study (R&D not included to ensure anonymity)

Appendix 4: University ethics approval for amendments

Appendix 5: Example cover letter, consent form and participation information sheet

Appendix 6: A copy of all questionnaires

Appendix 7: Publication of the realist synthesis

Authors	Year	Location	Healthcare setting	Participants	Intervention	Intervention type	Design	Duration
Adeniran, R.K. Rich, V.L. Gonzalez, E. Peterson, C. Jost, S. Gabriel, M.	2008	USA	The Hospital of the University of Pennsylvania	Internationally Educated Nurses	Transitioning Internationally Educated Nurses for Success (TIENS)	Transition programme - orientation, buddying, leadership/support in place.	*Descriptive study* - no empirical data collected.	Ongoing
Anderson, K. Sykes, M. Fisher, P.	2007	UK	REACHE North West, Salford Royal Hospitals NHS Foundation Trust	Refugee doctors and UK medical students	Communication skills programme	Small group work doing OSCE role plays	*Evaluation* - Qualitative - semi-structured interviews	One night per week
Atack, L. Cruz, E. V. Maher, J. Murphy, S.	2012	Canada	School of Nursing	Internationally Educated Nurses - 62 nurses completed survey. 29 nurses took part in first focus group (10 weeks into programme)– 12 from cohort 1 and 17 from cohort 2. All nurses from cohort 1 and 7 from cohort 2 took part in second focus group (completion of programme). Final data collection 3 months after graduation– telephone interviews with 9 nurses	Integrated Bridge Programme	Theory and clinical practice and a 15 week preceptorship module in which nurses will work full time with a staff mentor. They are required to take two college-level English courses and English language skills are embedded in course. Course on nursing in Ontario is also ran.	*Evaluation* – qualitative and quantitative. Using interviews and focus groups. Data was collected in the first semester, at the end of the programme and after the nurses started work/job search. Interviews analysed using process described by Creswell (2007). Descriptive statistics for questionnaires. Nursing registration examination pass rates for 2 cohorts also collected.	2 semesters of theory and clinical practice and a 15 week preceptorship module
Baker, D. Robson, J.	2012	UK	Dumfries and Galloway Royal Infirmary (NHS)	14 IMG participants, 3 opted out of language training - India (9), Pakistan (2), Sri Lanka (1), Libya (1) and Sudan (1)	Communication training	Communication programme - language and consultation skills training.	*Development, implementation, evaluation.* Implementation of intervention - 15 sessions of language training and six sessions of consultation skills training. *Evaluation* - qualitative and quantitative analysis - evaluated participants continuously throughout the programme. A language tutor and GP tutors assessed the language and consultation skills of the participants. Sought the opinion of clinical supervisors via e-mail using a questionnaire and conducted focus groups at the end of the programme.	6 months
Ballard, K. Laurence, P.	2004	UK	Department of General Practice and Primary Care, Kings College, London	33 EU GPs - French/ Belgian(2)	Induction Programme	Orientation, peer support, shadowing, supervision.	*Development, implementation, evaluation.* Implementation of intervention - induction pack, five sessions per week on one clinical placement, supervision of doctor, one to two sessions per week of English tuition, two sessions per week meeting educational needs, peer support once a week, ongoing support after 10 weeks. *Evaluation* - qualitative and quantitative. Group discussion with participants and facilitators, individual face-face interviews, written evaluation of educational seminars (including Likert scale), employment outcomes measured through follow-up telephone survey.	Initially 4 weeks, now 10 weeks
Beardsley, L. M.	1994	USA	Residency training programme at University of Illinois College of Medicine at Peoria	IMGs accepted onto residency programme	Acculturation training model	A four-faceted training programme - Intercultural training - clinical skills, intercultural attributions, English as a Second Language, social skills/socialisation.	*Descriptive* study - no empirical data collected.	Up to one year

Carlier, N. Carlier, M. Bisset, G.	2005	Australia	Rural South Australia - The Eyre Peninsula Division of General Practice	20 out of 22 IMGs who had arrived to work in the division between 1998 and 2003	Orientation for IMGs	Various orientations aiming to help the doctors understand and integrate into their new working environment.	*Evaluation* - A self-administered questionnaire - included questions around demographics, importance of orientation topics and confidence in these at end of orientation, content and practical aspects of orientation, and difficulties they and their family experienced.	Does not state
Cheung, C. R.	2011	UK	NHS Trust specialist paediatric centre	12 overseas trained doctors	Induction and support programme	Induction morning consisting of interactive presentations, workshops and role plays. Pastroral support and peer support system/buddying offered.	*Evaluation* - post-course questionnaire, post-course focus group and structured telephone interviews.	Induction half day/support over 2 months
Christie, J. Pryor, E. Paull, A.	2011	Australia	Southern Health, Victoria	8 IMGs	Communication training	Commincation skills - pronunciation, including intonation and stress; non-verbal behaviours; oral grammar; the language of case presentations, and managing examination stress.	*Evaluation*- Changes in the trainees' communication and language skills were evaluated by two independent speech pathologists, who rated two 2-minute video clips, recorded pre- and post-programme, respectively, for each trainee.Five senior medical staff also rated the video clips. Participants also completed pre- and post-questionnaires and a focus group ran.	12-week programme (1 day per week)
Coffey, S.	2006	Canada	School of Nursing, York University	Internationally Educated Nurses	Qualifying Pre-session/bridging programme.	Professionally relevant English language support, mentorship, academic upgrading, workplace experiences, and clinical skills support.	*Descriptive study* - no empirical data collected.	Does not state
Cohen Castel, O. Ezra, V. Alperin, M. Nave, R. Porat, T. Golan, A. Vinker, S. Karkabi, K.	2011	Israel	Israel Defence Force	Immigrant civilian physicians employed by the military for at least 3 years as primary care physicians - 28 learners on programme	Outcome based continuing medical education programme	Common problems in military primary care, communication skills, integrative course and practice managament. Small group teaching, interactive learning based on case presentations, discussions, role plays and simulation.	Design, implementation - Initial needs assessment . *Evaluation* - Pre/post evaluation - multiple choice exam. Before and after programme scores on qulaity assurance assessment, comparison to none intervention group over the 3 years retrospectively. OSCEs used to assess learning throughout. Self evaluation at end of third year.	3 year spiral curriculum - 54 bi weekly meetings of 6 hours (18 meetings per year).
Cole-Kelly, K.	1994	USA	Metrohealth Medical Centre	IMGs	Orientation - residency programme developed to improve sensitivity to IMGs	Survival skills seminar. Orientation - 3 half day sessions addressing multiple cultural heritages of residents, half day discussion about hierarchy of healers, other continuous general discussion sessions about psychosocial topics/concerns. Support group. Cultural retreat.	*Descriptive.*	3 hours survival skills seminar, orientation one month. Support group during first 2 months. One day cultural retreat.

Cross, D. Smalldridge, A.	2011	UK	Reache Northwest	20 IMGs	Safe and Effective Communication Skills course	The course included history taking, summarising, discharge summaries, presentation skills and a communication model (SBAR– Situation, Background,Assessment, Recommendation). Delivered through presentations, workshops and simulated patients. Ongoing feedback.	*Development* - designed by a multi-disciplinary team of language teachers and clinicians, taking into account a variety of linguistic, cultural and clinical issues to give IMGs an introduction to the communication skills required in the UK work environment. *Evaluation* - Feedback gathered from participants and tutors.	Session 1 - half day, session 2 - half day, session 3 - full day
Curran, V. Hollett, A. Hann, S. Bradbury, C.	2008	Canada	Rural communities and regional health authorities within the province	IMGs	Orientation	Various orientations.	*Evaluation* - Qualitative - semistructured telephone interviews with IMGs and medical services administrators.	N/A
Duncan, G. Gilbey, D.	2007	Australia	The Riverina/Murrumbidgee area of New South Wales, one of the three local training groups of Coast City Country Training.	GP registrars attached to the Riverina/Murrumbidgee Local Training Group - 13 from international backgrounds and 3 from an Australian background	Cultural and communication training	Poetry, discussions, reflection, feedback, role-plays.	*Development, implementation, evaluation.* Initial needs assessment to define some of the language and communication difficulties, which then led to the development of a new approach for communication training. Poetry selected and role-plays developed for small group setting. *Evaluation* - feedback gathered though questionnaires.	6 sessions per year
Fry, M. Mumford, R.	2011	UK	NHS Education South Central	Third year GP specialty trainees (ST3s)	Communication workshops	Role plays, feedback.	*Descriptive.*	Does not state
Gandhi, S. French, B.	2004	UK	NHS Trust in the North West of England	22 overseas graduate nurses	Adaption Programme	Classroom based teaching, mentor support, supervised practice, buddying, weekly group meetings portfolio of evidence.	*Descriptive.*	Minimum of 3 months
Gerrish, K. Griffith, V.	2003	UK	National Health Services (NHS) trust comprising two large acute hospitals and a specialist cancer hospital	17 overseas registered nurses - China, the Philippines, India, and sub-Saharan Africa	Adaption Programme	Classroom-based induction period, followed by a minimum of 10 weeks of supervised practice.	*Evaluation* - A pluralistic evaluation research model was adopted to identify the criteria that stakeholders used to judge the success of an adaptation programme, and then to use these criteria to judge the programme in question (develop framework). Data were collected by means of focus group and individual in-depth interviews with overseas nurses, ward managers, mentors, senior nurse managers and educators over a 12 month period and analysed by drawing on the principles of dimensional analysis.	2-week induction period, minimum of 10 weeks of supervised practice
Goldszmidt, M. Kortas, C. Meehan, S.	2007	Canada	Department of Medicine at a Canadian medical school	5 new internationally sponsored residents and 2 volunteer IMGs	'English for Medical Purposes' programme.	Communication skills, doctor patient and doctor–colleague interactions.	*Evaluation* - All 5 of the ISRs and 1 of the IMGs completed an anonymous post-programme feedback form consisting of 7 open and 24 7-point Likert scale questions.	18-hour programme, over 6 academic half-days
Greig, A. Dawes, D. Murphy, S. Parker, G. Loveridge, B.	2013	Canada	The University of British Columbia	Over 4 years 124 Internationally Educated Physiotherapists have participated	Internationally Educated Physiotherapists (IEP) Program Project	Written and clinical examination practice, workshops, mentoring.	*Development, implementation, evaluation.* *Evaluation* - Programme evaluation - formation of a program logic model followed by analysis of the outcomes defined in the model.The differences between National exam results for IEPs who had participated in the IEP Program compared with other internationally trained Physiotherapists who had notparticipated in the program were tested using Fisher's exact test.	Does not state

Hamoda, H. M. Sacks, D. Sciolla, A. Dewan, M. Fernandez, A. Gogineni, R. R. Goldberg, J. Kramer, M. Saunders, R. Sperber, J. Rao, N. R.	2012	USA	International Medical Graduate Committee of the Group for Advancement of Psychiatry.	IMGs preparing for psychiatry residency status	Observership programme	Observation, acculturation.	*Descriptive study* - no empirical data collected.	Various recommendations
Harris, A. Delany, C.	2013	Australia	Metropolitan hospital in Victoria	Ranged from 3 to 23 IMG doctors, averaging at nine doctors per session.	Transition in Practice	Orientation programme - reflective discussion group.	*Development, implementation, evaluation.* *Evaluation* - Use of evaluation cards at the conclusion of each session, Both open-ended (to capture participants' thoughts about what they had learned in each session) and more directed (to ask participants to feed back into the programme by recommending topics for future sessions).Thematic analysis conducted.	Six 1-hour informal meetings
Hawken, S.	2005	New Zealand	Aukland-based programme commissioned by Ministry of Health and the Clinical Training Agency	25 doctors that passed the first three intakes of the Overseas Doctors Training Programme	Professional Development component of the Overseas Doctors Training Programme	Communication skills, ethics, medico legal obligations, and Maori and Pacific issues.	*Evaluation* - Questionnaires sent to all those that had passed the first three intakes of the programme; measuring the perceived usefulness of the course components as well as participants' perceptions of their own level of skills. Qualitative data also collected.	Training programme - Part A - 18-week Part B - 6-month
Heal, C. Jacobs, H.	2005	Australia	Mackay, north Queensland	Newly arrived IMGs	Peer Support Programme	Support network; discussions based on needs assessment.	Descriptive *study*. Feedback sought at first and last meetings through questionnaires.	6 x fortnightly meetings
Higgins, N. S. Taraporewalla, K. Edirippulige, S. Ware, R. S. Steyn, M. Watson, M. O.	2013	Australia	Royal Brisbane and Women's Hospital	6 cohorts of Specialist IMGs preparing for specialist examinations	Facilitated tutorial	Guided tutorials, face-to-face or through videoconferencing. Group discussion/peer interaction.	*Evaluation* - Content analysis techniques were used to measure candidates' level of learning and preparation. The association between concept measures and exam success was investigated.	Weekly 2-hour VC sessions, delivered in two tutorial blocks per year over the period of the study
Horner, M.	2004	UK	Leeds Teaching Hospitals NHS Trust	106 International nurses from Singapore and the Philippines, 25 mentors	A competency-based supervised practice programme	Mentors were appointed to facilitate the nurses' integration into the UK nursing culture and to promote understanding of policies and procedures specific to the trust.	*Evaluation* - A series of individual semi structured interviews were undertaken with the IRNs, forming the basis for structuring the questionnaires. These were sent to the known 460 IRNs in the trust to elicit their view of the supervised practice programme. Anonymous questionnaires were also sent to 100 known mentors in order to explore mentorship preparation and support.	Mean time taken to complete was 3.42 months.
Horvath, K. Coluccio, G. Foy, H. Pellegrini, C.	2004	USA	The University of Washington (UW) general surgery residency program	4-10 IMGs per year	Certificate Programme	Clinical experience - IMGs are required to take full responsibility for all ward activities under direct supervision.	Longitudinal study. Retrospective analysis. Description of a new program.	8 weeks
Julian, M. Keane, A. Davidson, K.	1999	USA	School of Nursing, University of Pennsylvania, Philadelphia	IMGs on nursing programme	Language Plus program	English-Language support programme - six main skill areas are identified and practice on these skills is undertaken in tasks such as role playing. One individual tutor session per week.	*Descriptive - Development/implementation.*	Over three semesters - 20 x 90 minute sessions

Lax, L. R. Russell, M. L. Nelles, L. J. Smith, C. M.	2009	Canada	University of Toronto.	IMGs seeking licence to practice - Study 1 (N = 20) Study 2 (N = 39) Study 3 (N = 33)	Web-Based Communication and Cultural Competence (CCC) Program	The programme is composed of five medical cases and a Communications Skills Module. Use of simulated doctor/patient video vignettes, contextualized resources, "Knowledge Checks" with embedded concurrent feedback, "Reflective Exercises" highlighting ethical dilemmas and "Commentaries" with expert feedback.	*Development and implementation* - Data was gathered from IMGs at strategic points in program development, though the use of questionnaires, focus groups and online data collection of programme use. Inductive feedback and verification analyses informed iterative development of the CCC Program, leading to its completion and implementation the following year.	N/A
Maudsley, R.	2008	Canada	College of Physicians and Surgeons of Nova Scotia	148 IMGs	The Clinical Assessment for Practice Programme	A therapeutics exam and an objective structured clinical examination to assess practice readiness. Followed by a 12 month mentorship - active practice. Teaching, supervision, guidance, individualised continuing medical education plan, regular assessment, external assessment, multisource feedback. Review after 12 months.	*Descriptive.* *Evaluation* - outcomes (eligibability for license).	12 months
MacLellan, A. M. Brailovsky, C. Miller, F. Leboeuf, S.	2012	Canada	College des Medecins du Quebec, Medical Education Division	810 IMGs who applied to the College des medecins du Quebec through either the "equivalency pathway" (ie, starting training at a residency level) or the "clerkship pathway" (ie, relearning at the level of a medical student in the last 2 years of the MD diploma)	Clerkship pathway	Re-education programme.	Retrospective analysis of 810 files of IMGs was completed. The study design identified and quantitatively analysed more than 58 variables.	2 years
Majumdar, B. Keystone, J. S. Cuttress, L. A.	1999	Canada	Ontario International Medical Graduate Programme (OIMGP) - University of Toronto	24 IMGs who had completed the 9 month OIMGP	Cultural sensitivity training	Sessions focused on cultural self-awareness and cultural senitivity; teaching skills to enable the practice of these competencies. Use of group discussion, simulated patient and videos.	*Development, implementation, evaluation* . Training manual designed and implemented. *Evaluation* - A study of pretest-post-test design was conducted to determine the effect of cultural sensitivity training on newly immigrated physicians licensed in Canada. Those who were given the training were considered the experimental group. This group was compared with a control group of 24 physicians who had passed the licensing exam and were in the process of completing residency, but recieved no training.	15 hours - 5 x 3 hour sessions
McGrath, P. Henderson, D.	2009	Australia	Department of Medicine at the Redland Hospital, Queensland	9 IMGs	Observer programme	A hospital based pre-employment program for IMGs.	An open-ended, exploratory qualitative design was utilised for the study. *Evaluation* - In-depth, open-ended interviews were conducted with nine IMGs who had been part of the OP.	3 months - trainees were expected to work seven to eight hours a day, four to five days a week

McGrath, P. Henderson, D. Phillips, E.	2009	Australia	Department of Medicine at the Redland Hospital, Queensland	9 IMGs	Overall integration process - including Observer Programme	A hospital based pre-employment program for IMGs.	An open-ended, exploratory qualitative design was utilised for the study. *Evaluation* - An iterative, qualitative research methodology was utilised, using open ended interviews with IMGs about their experience and involvement with the observer program.IMGs experience before, during, and after their involvement was assessed.	3 months
Myers, G.	2004	USA	Southern Illinois University School of Medicine - Department of Psychiatry	12 IMG psychiatry residents and one United States graduate (USG)	Curriculum addressing cultural differences in boundary-keeping practices.	8 seminars - discussion of guidleines and theory, personal stories concerning relational boundaries, role plays, constructionof cultural difference grid.	*Development, implementation, evaluation.* Implementation of curriculum - First 4 sessions focus on theory and concepts, last 4 sessions involve innovative focus and content of the curriculum. *Evaluation- Quantitative analysis - the* effectiveness of the curriculum was evaluated through post-then-pre-assessment instrument in the final seminar. Discussion of observations.	8 monthly, 1-hour seminars
Neill, D. Slattery, H. Handrinos, D. Holloway, S.	2011	Australia	The Committee for Specialist International Medical Graduate Education - developed programmes across different locations.	Specialist IMGs	Various up skilling programmes	Various - includes up skilling workshops, communication skills, cultural enhancement, mentoring, exam preparation, development of learning plans and seminars.	*Descriptive* - no empirical data collected.	Various programme durations
Nelles, L. Smith, C. Lax, L. Russell, L.	2011	Canada	University of Toronto	IMGs	Communication and Cultural Competence Programme	Interactive web-based programme. Video simulation used.	*Descriptive* - process and methodology.	N/A
Nestel, D. Regan, M. Vijayakumar, P. Sunderji, I. Haigh, C. Smith, C. Wright, A.	2011	Australia	Rural Victoria, Australia	See Wright et al. (2012)	Gippsland Inspiring Professional Standards for International Experts (GIPSIE) programme	An evaluation strategy to elicit development in trainees' knowledge, attitudes, and skills and detect sustained changes in clinical practice.	*Development and implementation* of the evaluation strategy for the programme.	See Wright et al. (2012).
Ong, Y-L. McFadden, G. Gayen, A.	2002	UK	London Deanery	Overseas doctors - only those who had been appointed to a substantive job in London were included.	Induction for overseas qualified doctors	Four training modules with formal didactic presentations mixed with interactive learning sessions - communication skills, the NHS, preparing for the next post and multicultural issues.	*Descriptive* - No data collection. Describes development and evaluation.	Does not state length of modules
Parry, M. Lipp, A.	2006	UK	Adult cancer hospice	15 internationally recruited nurses	Adaption Programme	Preparation of the hospice in overcoming practical issues, mentoring, lectures, workshops, discussion, role-play, case studies (introduction, communication, roles, legal and ethical, patient care, cultural issues, team work, refelective practice, professional development etc.)	*Evaluation* - questionnaire. Led to further development of programme.	12 weeks - one study day per week

Porter, J. L. Townley, T. Huggett, K. Warrier, R.	2008	USA	Creighton University	IMGs prior to beginning residency	Precourse - an acculturisation curriculum	Mixture of lectures followed by standardised patient encounters. Practice writing from clinical vignettes. Large amount of time spent ward-rounding. Covered issues around communication, practical skills, the new system, procedures etc.	*Evaluation* - pre/post test. Standardised patient envounters. Interviews with stakeholders RE perceptions of precourse.	2 weeks
Rabin, S. Herz, M. Stern, M. Vaserfirer, I. Belakovsky, S. Mark, M. Ribak, J.	1996	Israel	Employed by Israel Ministry of Health - community clinics	25 physicians who had immigrated from Russia to Israel.	Balint group method	Group discussion/support	*Evaluation* - questionnaire testing self-efficacy administered at 4 points - at beginning, after 6 months, after 18 months and at the end of the programme (30 months).	Ongoing (30 months) - twice per month for 2 hours
Rich, A.	1998	UK	Sunderland Royal Hospital	9 overseas doctors attended - 7 from the EEA and 2 from Asia.	Induction programme for overseas doctors starting their first appointment in the UK	The induction programme was arranged in three parts: a distance learning module mailed to the overseas doctors in advance; a course of structured lectures, workshops and seminars; and a period of work shadowing.	*Description of development and implementation.* *Evaluation* - Feedback sessions and daily course evaluations.	2 weeks
Romem, Y. Benor, D. E.	1993	Israel	Ben-Gurion University	273 immigrant doctors	6 month intensive course	20 week curriculum - learning about different clinical fields and common conditions. Emphasis on learning languages. Lectures, small group activities and problem-orientated learning. Social aspects.	*Evaluation* - examination success rates of trainees who took part in programme, in comparison to those who took the examination without attending the programme.	6 months
Rosner, F. Dantzker, D. R. Walerstein, S. Cohen, S.	1993	USA	Internal medicine residency program at Queens Hospital Centre	Offered to all IMGs just prior to the beginning of their internal medicine one- or three-year residencies.	Orientation for IMGs	Intensive orientation program focusing on clinical competencies. Consisting of videos, presentations, group discussion, clinical case discussions and ward-rounds.	*Description of implementation.* *Evaluation* - orientation evaluation questionnaire is given to each of the IMGs for completion at the end of the orientation.	5 days
Rothman, A. I. Cohen, R. Ross, J.	1996	Canada	Ministry of Health	IMGs (24 per year) - 2 cohorts	Ontario Pre-Internship Programme	8 weeks each of medicine and surgery, 4 weeks of family medicine, pediatrics, psychiatry, gynecology, seminars describing Ontario's health care system. Examination at end of programme.	*Evaluation* - pre/post tests - OSCE style clinical skills examination prior to and after programme.	36 weeks
Ryan, M.	2003	USA	USA community hospital	International Nurses	Buddy programme	Orientation - earliest phase of acculturation	*Descriptive* - describes development and implementation.	2 weeks
Shen, J. Xu, Y. Bolstad, A. Covelli, M. Torpey, M. Colosimo, R.	2012	USA	Community hospital in a U.S. southwestern metropolitan area	32 Internationally educated nurses in the intervention group, 29 in the comparison group	Phonologic accent reduction course	Linguistic course	Quasi-experimental design. *Evaluation* - pre/post test - one hospital primarily served as the intervention group while the other served as the comparison group.	10 week - ten 2-hour sections

Sierles, F.	2005	USA	Rosalind Franklin Psychiatry Residency	PGY- 1 psychiatric residents	Acculturation course	Film based programme covering relevant cultures. 5 films shown followed by discussion.	*Descriptive* - Discusses relevant cultures depicted within each movie. *Evaluation* - pre/post test multiple choice exam and course satisfaction feedback.	3-hour blocks x 5
Smalligan, R. Khandheria, B. Richey, H. Bell, T. Jordan, R. Weis, B.	2011	USA	Department of Internal Medicine, Texas Tech University	Incoming residents	Simulation internship	Procdures paracticed - central lines, art lines, chest tube, sterile glove, gown, paracentesis and thoracentesis intubation, airway, pelvic exams, handoffs.All scenarios include patient history (script), past medical history, report of family members, labs, radiology reports, vital signs (fluctuate).	*Evaluation* - pre/post tests to assess comfort levels.	1 week
Steinert, Y. Walsh, A.	2006	Canada	Health Canada	Teachers of IMGs	Faculty Development Program for Teachers of IMGs	This program consists of four main sections: 1. Orienting Teachers and IMGs, 2. Educating for Cultural Awareness, 3. Working with IMGs – A Faculty Development "Toolbox", 4. Guidelines for Site-Specific Activities: Faculty Development Principles and Strategies.	*Descriptive* - no empirical data collected.	N/A
Stenerson, H. J. Davis, P. M. Labash, A. M. Procyshyn, M. M.	2009	Canada	The Division of Continuing Professional Learning, College of Medicine, University of Saskatchewan	107 IMGs	Orientation programme for IMGs	DVD, an orientation guide, and a two-day conference.	*Evaluation* - survey.	2 days
Sullivan, E. A. Willcock, S. Ardzejewska, K. Slaytor, E. K.	2002	Australia	New South Wales Postgraduate Medical Council (PMC)	66 Overseas Trained Doctors who had passed their Australian Medical Council (AMC) exams and were applying for a pre-registration year in New South Wales (1997, 1998, 1999)	A pre-employment programme for overseas-trained doctors entering the Australian workforce	Consisted of core group teaching and a hospital attachment. The curriculum included communication, health and workplace skills; and sessions on culture shock and the role of junior doctors.	*Descriptive* - Description of programme and findings. *Evaluation* - The assessment was extensive and comprised a hospital evaluation; a survey of all those invited to enrol in the programme, to identify determinants for enrolment; pre- and post-test questionnaires, to be completed before and after attending the programme, and a focus group 3 months after completion of the programme.	4-week full time
Tan, R. A. Alpert, P. T.	2013	USA	Long-term care facility in a South-western US state	18 internationally educated nurses underwent the training and completed both pre/post surveys	Pre-employment simulation training	Adverse cardiac event with use of computer-assisted simulation training.	*Descriptive* - Description of programme and findings. *Evaluation* - pre/post questionnaires (The Simulation Confidence Scale) measured the confidence level of individuals – completed in orientation session and after last simulation session.	5 hours - one orientation session followed by 2 simulation sessions (2 hours each total - 15-20 minutes per person for each scenario)

Tan, A. Hawa, R. Sockalingam, S. Abbey, S.	2013	Canada	1-year clinical fellowship in psychosomatic medicine at the University Health Network, a teaching hospital affiliated with the University of Toronto	4 IMG fellows who completed a psychosomatic medicine fellowship	Teaching for Learning and Collaboration (TLC) Program	Orientation - Clinical teaching skills-development program. Consisted of 1. Setting an Educational Climate, 2. Identifying Learner Needs and Setting Goals, 3. Checking In and Making Learning Stick, 4. Feedback.	*Descriptive* - Description of framework development, implementation and findings.	One year - feedback every three months or as needed.
Watt, D. Violato, C. Lake, D. Baig, L.	2010	Canada	Universities of Calgary and Alberta	274 IMGs	Medical Communication Assessment Project (M-CAP)	Medical communication and clinical skills education programme - 8 week diadic course (langauge instructors, standardised clincal case scenarios, role plays, reflection, feedback) and 8 week supervised clinical placement.	Design/Evaluation -repeated measures pre-post-test design to assess language efficiency and training evaluation report. Comparison group analysis on OSCE data using MANOVA.	16 weeks
Woodward-Kron, R. Fraser, C. Pill, J. Fkynn, E.	2014	Australia	Melbourne medical school/2 Victorian public hospitals	48 IMGs, primarily working as hospital medical officers, preparing for clnical examination took part in OSCE workshops. 25 IMGs completed evaluation.	Web-based resource *Doctors Speak Up*	Evidence-based language and communication skills open access online resource - short videos, interactive tasks, multiple choice questions.	*Development* - based on OSCE workshops and feedback that were video recorded and analysed. *Evaluation* - online evaluation.	N/A
Woodward-Kron, R. Flynn, E. Delany, C.	2011	Australia	The Postgraduate Medical Council Victoria (PMCV)	IMGs	Multimedia resources	Clinical and ethical communication training through multimedia - consists of three video clips of challenging communication scenarios as well as experienced IMGs talking about communication and ethics. The multimedia are supported by teaching guidelines that address relevant disciplinary concerns of the three areas of collaboration.	*Descriptive* - processes and dynamics of the collaboration, outline of methodologies from applied linguistics, medical education, and health ethics. *Development* - (1) decision making: content and approach; (2) script writing and filming; and (3) production and development of supporting materials. I*mplementation*.	Does not state.
Woodward-Kron, R. Stevens, M. Flynn, E.	2011	Australia	Urban teaching hospital in the state of Victoria, Australia	IMG's preparing for OSCEs IMGs filmed - 11 in the OSCE sessions; 9 in the regular sessions. IMGs from the Indian subcontinent, Iran, and China. Attendance in these voluntary sessions ranges from 5 to 14 trainees.	Communication and language feedback (CaLF)	Methodology to aid in giving feedback to IMGs after communication practice sessions (interviewing a patient); using a simulated patient. Consists of video recording and written comments (via CaLF tool).	*Development, implementation, evaluation.* Observational research phase (phase 1), Developmental phase (phase 2) and Implementation and Evaluation phase (phase 3). *Evaluation* - ongoing process evaluation designed to inform the development of the CaLF tool and methodology as well as a summative evaluation toward the end of the eight-month project. Evaluation included observation of improved communication skills for participating IMGs and their success in the clinical exam. Also recorded improved communication via longitudinal comparisons of individual IMGs' performance and feedback received from the MCE, simulated patient, and linguist.	2-hour weekly sessions

Wright, A. Regan, M. Haigh, C. Sunderji, I. Vijayakumar, P. Smith, C. Nestel, D.	2012	Australia	IMGs were recruited from hospitals (n=15) and general practices (n=2) across the region (rural Australia)	17 participants registered for the program (10 male and 7 female), aged 27 to 51 years (mean=35). Participants came from 12 countries (Sri Lanka, the Philippines, Colombia, India, Bulgaria, Bangladesh, Iran, Afghanistan, Vietnam, China, Egypt and Bosnia) and spoke 14 languages (other than English). Participants had been in Australia between 2 and 120 months (mean=46) and in Gippsland for 2 to 42 months (mean=13).	The Gippsland Inspiring Professional Standards among International Experts (GIPSIE) program	Professional development program - communication with patients/relatives, communication with colleagues/health professionals, clinical skills, patient management.	*Development, implementation, evaluation.* Implementation of intervention - 2 day weekend workshop, , 4 fortnightly evening meetings and workplace observation. Simulation-based training was a prominent theme and addressed clinical knowledge, attitudes and skills. Diverse clinical communication skills were explored. GIPSIE was underpinned by a website offering diverse learning resources. Content experts lead sessions integrating knowledge and skills reflecting local practice. *Evaluation* - pre- and post-program 15 item multisource feedback (MSF), post-program questionnaires and, in order to address retention, telephone interviews exploring participants' responses 3 months after the program finished.	An immersion weekend workshop preceded 4 fortnightly evening meetings. 24 contact hours, plus 3 hours observation - ran over 3 months
Xu, Y.	2010	USA	School of Nursing, University of Nevada	International Nurses	Evidence based transition programme	Didactic component - langauge/communication, clinical skills/knowledge, interpersonal skills, policy/procedures, health care system in comparative perspectives, comparison of cultures. Clinical component - period of supervised nursing practice (mentoring).	*Descriptive.*	Up to 12 months
Xu, Y. Bolstad, A. Shen, J. Colosimo, R. Covelli, M. Torpey, M. Jorgenson, M.	2010	USA	2 urban hospitals in Sothern Nevada (single-healthcare system)	79 international nurses Phase 1 - 32 in intervention group and 29 in comparison group. Phase 2 - 18 in intervention group and 10 in comparison group.	Linguistic intervention	Linguistic course and 4 workshops on social and cultural aspects of communication.	Quasi-experimental design - two independent phase study. Implementation and evaluation. *Evaluation* - pre/post tests.	10 week linguistic course, 4 culture workshops (16 weeks in total)

Durham University

School of Medicine, Pharmacy and Health

Shaped by the past, creating the future

Rebecca Maier
Research, Development and Trials Manager
Chair, School of Medicine, Pharmacy and Health Ethics Sub-Committee

Amelia Kehoe
PhD Student
School of Medicine, Pharmacy and Health
Durham University

30th April 2014

Dear Amelia,

Re: Ethics Application ESC2/2014/PP03
A realist synthesis of the interventions used to support overseas medical graduates in their transition to work in another country – an evaluation

Thank you for sending the above application to the School of Medicine, Pharmacy and Health Ethics Sub-Committee for proportionate ethical review. I reviewed this project as Chair of the committee. The project is an evaluation and review by the full committee is therefore not required. No significant ethical issues were identified, and I am pleased to confirm Durham University ethical approval for the evaluation.

This approval is given on the following basis:

- That data generated for this study is maintained and destroyed as outlined in this proposal and in keeping with the Data Protection Act.
- If you make any amendments to your study, these must be approved by the committee prior to implementation.
- At the end of the study, please submit a short end of study report (ESC3 form) to the School ethics committee.

Please do not hesitate to contact me should you have any questions. Good luck, I hope that the evaluation goes well.

With best wishes,

RHMaier

Rebecca Maier

Durham University

School of Medicine, Pharmacy and Health

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Dr David Ekers
Clinical Senior Lecturer
Chair, School of Medicine, Pharmacy and Health Ethics Sub-Committee

Amelia Kehoe
School of Medicine, Pharmacy and Health
Durham University

13th August 2014

Dear Amelia,

Re: Ethics Application ESC2/2014/09
Support for overseas doctors: Evaluation of an intervention framework to aid successful transition to the UK.

Thank you for sending the above application to the School of Medicine, Pharmacy and Health Ethics Sub-Committee for ethical review. The project was reviewed at a meeting on 16th July 2014. The committee requested some changes to the application, and I have now reviewed these as Chair. I am satisfied that all of the comments made by the committee have been addressed and I am therefore pleased to confirm Durham University ethical approval for the study.

This approval is given on the following basis:

- Please ensure that data generated for this study is maintained and destroyed as outlined in this proposal and in keeping with the Data Protection Act.
- If you make any amendments to your study, these must be approved by the School committee prior to implementation.
- At the end of the study, please submit a short end of study report (ESC3 form) to the School ethics committee.

Please do not hesitate to contact me should you have any questions. Good luck, I hope that the study goes well.

With best wishes,

David Ekers

Durham University

School of Medicine, Pharmacy and Health

Shaped by the past, creating the future

Dave Ekers
Clinical Senior Lecturer - Psychological Interventions
Chair, School of Medicine, Pharmacy and Health Ethics Sub-Committee

Amelia Kehoe
School of Medicine, Pharmacy and Health
Durham University

23rd October 2014

Dear Amelia,

Re: Amendment to ESC2/2014/09
Support for overseas doctors: Evaluation of an intervention framework to aid successful transition to the UK

Thank you for forwarding the minor amendment (1) to the above application to the School of Medicine, Pharmacy and Health Ethics Sub-Committee. I have reviewed the amendment as Chair of the committee and I am pleased to confirm ethical approval.

This approval is given on the following basis:

- Governance approval to run the study at participating NHS Trusts is gained prior to starting the research
- Please ensure that data generated for this study is maintained and destroyed as outlined in this proposal and in keeping with the Data Protection Act.
- If you make any amendments to your study, these must be approved by the School committee prior to implementation.
- At the end of the study, please submit a short end of study report (ESC3 form) to the School ethics committee.

Please do not hesitate to contact me should you have any questions. Good luck, I hope that the study goes well.

With best wishes,

David Ekers

Durham University
School of Medicine, Pharmacy and Health

CONSENT FORM

Title of Project: **Evaluation of an intervention framework to aid successful transition to the UK**

Name of Researcher: Amelia Kehoe

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I am free to withdraw at any time during the study and within one week of completion, without giving any reason. ☐

3. I understand that any information I provide will be audio-recorded, stored securely, anonymised and confidentiality assured. ☐

4. I am happy for the researcher to have access to anonymous performance data obtained through the Trust. ☐

5. I agree to take part in the above study, knowing that the information I provide will be analysed and findings may be used as part of a PhD project ☐

6. I give permission for the researcher to contact me in relation to a follow-up interview or focus group. ☐

Name of Staff member:	Date:	Signature:
Researcher:	**Date:**	**Signature:**
Amelia Kehoe		

Centre for Medical Education Research
School of Medicine, Pharmacy and Health
Burdon House
Leazes Road
Durham
DH1 1TA
Email: amelia.kehoe@durham.ac.uk
Mobile: 07792510639

Dear staff member

We are carrying out research evaluating the implementation and impact of interventions that are currently being ran for overseas doctors within your Trust; seeking to look particularly at their impact in aiding transition into the UK, and we would like to invite you to take part in this research evaluation.

The primary purpose of the research is to produce a PhD thesis. However, we anticipate that this work will also inform future policies and have a beneficial impact on the working lives of overseas medical graduates working in the NHS. We need your feedback to help us to highlight successful elements, as well as areas for improvement.

The initial part of the research involves the completion of questionnaires on training programmes provided. If you would like to take part, please complete the enclosed questionnaire concerning today's training and return it to the researcher. Completing this questionnaire should take around 15 minutes. A final questionnaire will be given at the end of the programme, taking a further 15 minutes. Questionnaires will also be distributed at future training sessions.

Another element of the research involves interviews and focus groups to explore your views and experiences in greater depth. Enclosed is an information sheet that tells you more about the study. If you are interested in taking part, please complete the enclosed reply slip and we will contact you at a later date to arrange a suitable time and location for a one-to-one interview. We will also provide details about location and times of the focus groups.

If you have any queries about the evaluation, you can contact me using the details provided above. Alternatively you can contact Jan Illing (supervisor) at j.c.illing@durham.ac.uk. Thank you in advance for your time.

Yours sincerely,
Amelia Kehoe
(PhD Student)

Durham University
School of Medicine, Pharmacy and Health

Information Sheet: Interventions for Overseas Doctors Evaluation

You are invited to take part in an evaluation study that is investigating the **impact of interventions for overseas doctors to aid successful transition to the UK**. Before you decide whether you would like to participate, we would like to describe why the research is being conducted and what will be involved. Please take time to read the following and ask the researcher if you would like any further information.

1. What is the purpose of the research study?

The purpose of the research evaluation is to enable a better understanding as to whether training and support programmes, such as the ones you will be attending, have a positive impact on the transition of overseas doctors to the UK. It is also of interest to see how these programmes achieve their outcomes.

The primary purpose of the research is to produce a PhD thesis. However, we hope this work will inform future policies and have a beneficial impact on the working lives of overseas medical graduates working in the NHS.

2. Why have I been chosen?

You have been invited to take part in this evaluation as you have been chosen by your trust to attend the programmes for overseas doctors. All doctors attending these programmes have been invited to participate.

3. Do I have to take part?

No, participation in this study is entirely voluntary. If you do not wish to be involved you do not need to take part, and you may withdraw at any time. In such case, we will not collect any data. Even if you agree to take part you may still withdraw from the study within one week of completion, without giving a reason. This can be done by stating your unique ID code. Any data that has been collected from you will be destroyed immediately, if you wish.

4. What will happen to me if I take part?

If you decide to take part, please complete the consent form and place it in the envelope provided and hand it back to the researcher.

The initial part of the research involves the completion of questionnaires on the training programmes provided. If you would like to take part, please complete the enclosed questionnaire concerning todays training and give it back to the researcher once completed. Completing this questionnaire should take around 15 minutes. A final questionnaire will be given at the end of the programme, taking a further 15 minutes. Questionnaires will also be distributed for future training sessions in the same way.

If you agree to take part in future interviews, please complete the information slip attached and we will contact you to arrange a suitable time and place to complete an interview. Further information will be sent to you about the interview process. You can contact us to ask any questions before you take part, and you may change your mind at any time and choose not to take part.

Interviews will take place in a quiet place in your working environment. The interviews will last between 20-40 minutes, although this may vary depending on individuals' circumstances.

The interviews will be audio taped, but we will protect your anonymity by assigning your ID codes to the individual interview tapes – your name will not be used or associated with this code. We will then transcribe the recording to a written document which we will use for our analysis. We will ensure throughout that anonymity is assured. No personally identifiable data will be included in the transcripts.

The consent form will also ask for your consent for the researcher to access ***anonymised*** performance data. This is merely to assess programme effectiveness and not individual performance. As explained below, no data will be personally identifiable to you as your ID code will be the only information available to the researcher. If you are happy for the researcher to access this information, please state your unique ID code and name on the slip attached to the information pack. This will be removed by a Trust member and stored separately from any data available to the researcher; ensuring anonymity of performance data.

You will be asked to provide an ID code that is anonymous, unique and memorable (the last 4 digits of phone number) to enable us to link all questionnaires at the analysis stage. Performance data will also be linked to the codes to ensure anonymity. Consent forms will be stored within the University in a secured filing cabinet, and will be stored separately from any data that is collected by the researcher. Trust staff will securely store the information provided on the attached slip; containing your ID code and name. The Trust will have no access to any questionnaires or interview data. The researcher will have no access to personally identifiable information, including your name.

The researcher will be making observations throughout the programmes, yet once again it is assured that no identifiable information will be transcribed.

5. What will happen to the data that is collected?

All information that you provide is confidential and anonymous. You will be asked to provide your name on the initial consent form and additional contact information; however this will be stored in a secured filing cabinet within the University and kept separate from your data.

Your responses to questionnaires will be analysed along with other returned questionnaires from the Trust. The data from completed questionnaires will be stored on a secure database, which will then undergo analysis by the researcher.

The audio recordings of interviews will be sent to a transcription company who will transcribe the recording into a typed document. Interview recordings will be assigned your unique ID code to maintain anonymity. The transcript will be sent back to the researcher who will analyse it alongside other interview transcripts. Following transcription, the original audio file will be securely destroyed.

We may publish direct quotations, but these would be entirely anonymous and we would remove any identifiable content that might breach anonymity (e.g. names, ward names).

If you would like to withdraw your data from analysis, please contact the researcher within one week of completion with your unique ID code to enable data removal. After analysis has been conducted, the original questionnaires will not be required anymore and will be destroyed. The data collected from all questionnaires and interviews will continue to be stored on a secure database for 5 years. Consent forms will be stored in a secure filing cabinet, upon which consent forms will be safely destroyed after 5 years.

6. What will happen to the results of the research study?
The results of this study will increase our understanding of what should be included in transition programmes, how they should be implemented and whether current programmes, such as the one you will be attending, have the desired effect in aiding transition into the NHS. After analysis, the aggregated findings will be included in a PhD project. Findings may also be disseminated through publications and conferences. However, there will be no way to identify individuals who contributed to the research.

7. Will my taking part in this study be kept confidential?
Any information collected from you during the course of the programme will be kept strictly confidential. You cannot be identified in any way and responses will only be reported in aggregate. No questions asked in this research will enable you to be identified. However, if issues arise that may be considered malpractice; the researcher will respond in the most appropriate way recommended by the Trust.

8. Who is organising and funding the research?
The research is funded by North Tees and Hartlepool NHS Foundation Trust and is being led within the trust by Professor Jane Metcalf. The evaluation itself is led by Amelia Kehoe, PhD student at Durham University, and supervised by Professor Jan Illing, Professor John McLachlan, Dr Madeline Carter and Dr Simon Forrest.
This research project has been reviewed and approved by Durham University School of Medicine, Pharmacy and Health Ethics Committee. It has also been approved by your employing Trust, which means the Trust is in agreement with the project being conducted.

9. Whom to contact for further information
If you have any further questions about this evaluation, please feel free to contact:

Amelia Kehoe (PhD Student)
Address: Durham University
Centre for Medical Education Research
School of Medicine, Pharmacy and Health
Burdon House
Leazes Road
Durham
DH1 1T
Tel: 07792510639
Email: Amelia.Kehoe@durham.ac.uk

Jane Metcalf (Clinical Director of Education and Organisational Development)
Address: University Hospital of North Tees
Hardwick
Stockton
TS18 9PE
Tel: 01642 624722
Email: Jane.Metcalf@nth.nhs.uk

Jan Illing (Supervisor)
Address: Durham University
Centre for Medical Education Research
School of Medicine, Pharmacy and Health
Burdon House
Leazes Road
Durham
Tel: 0191 3348202

Durham University
School of Medicine, Pharmacy and Health

Pre-programme questionnaire

Questionnaire for NHS Staff

Please complete the questionnaire as fully as possible and return to the researcher

Your responses will remain wholly **confidential** to the researcher. Only aggregated responses will be presented to the NHS Trust or appear in publications.

If you have any questions please contact Amelia Kehoe (amelia.kehoe@durham.ac.uk)

ID CODE: .....

A. Expectations/needs

1. **What is your current level of medical training?** .....
2. **What previous experience/training/held position do you have (if any)?**

   .....
3. **How long have you been living in the UK?** .....
4. **What do you expect to gain from this programme?**

5. **Do you feel that you are in need of this programme to help with your adjustment to the UK?**

   Yes/No (please circle)
6. **What areas of adjustment are you currently struggling with (if any)? (please tick)**

☐ **Social aspects** ☐ **Language/communication** ☐ **Accommodation** ☐ **Relationships with colleagues**

☐ **Finance** ☐ **Homesickness** ☐ **New culture of UK** ☐ **NHS structure**

☐ **Hospital environment** ☐ **Lack of information** ☐ **Dealing with different sorts of people**

☐ **Other (please state)**

7. What support is in place to help you with these issues? If no support is in place, do you know where to go to get support?

8. Do you currently feel you are a valued member of the trust in which you are working? Yes/No (please circle)

How much do you agree? (please tick)	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9) I am happy to have been given the chance to learn more about NHS good practice	☐	☐	☐	☐	☐
10) I am motivated to improve my current practice	☐	☐	☐	☐	☐
11) I am aware of my strengths in practice	☐	☐	☐	☐	☐
12) I am aware of my weaknesses in practice	☐	☐	☐	☐	☐
13) Self-reflection is critical for continual improvement	☐	☐	☐	☐	☐
14) Feedback is essential to help my development	☐	☐	☐	☐	☐
15) I am fully aware of what is expected of me within the NHS	☐	☐	☐	☐	☐

16) I am confident in my knowledge of guidelines that I must follow to ensure good practice	☐	☐	☐	☐	☐
17) I am confident in my ability to manage cultural differences that may occur in practice	☐	☐	☐	☐	☐
18) I am confident that I understand the structure and hierarchy of the NHS	☐	☐	☐	☐	☐
19) I am confident that I would be able to deal with a safeguarding issue (such as a patient suffering from abuse) effectively	☐	☐	☐	☐	☐
20) I am confident in my history taking, summarising and handover abilities	☐	☐	☐	☐	☐
21) I am confident that I can work as a member of a Multidisciplinary Team	☐	☐	☐	☐	☐
22) I am confident in my understanding of protocols to follow involving informed consent and confidentiality	☐	☐	☐	☐	☐
23) I am confident that I can manage an acute situation	☐	☐	☐	☐	☐
24) I am confident that I would be able to manage a situation involving error	☐	☐	☐	☐	☐

B. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS. Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Agree	Somewhat Agree	Agree	Disagree	Somewhat Disagree	Strongly Disagree
1. The doctor is the one who should decide what is talked about during a visit	☐	☐	☐	☐	☐	☐
2. Although health care is less personal these days, this is a small price to pay for medical advance	☐	☐	☐	☐	☐	☐
3. The most important part of the standard medical visit is the physical examination	☐	☐	☐	☐	☐	☐
4. It is often best for patients if they do not have a full explanation of their medical condition	☐	☐	☐	☐	☐	☐
5. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	☐	☐	☐	☐	☐	☐
6. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	☐	☐	☐	☐	☐	☐
7. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	☐	☐	☐	☐	☐	☐
8. Many patients continue asking questions even though they are not learning anything new	☐	☐	☐	☐	☐	☐
9. Patients should be treated as if they were partners with the doctor, equal in power and status.	☐	☐	☐	☐	☐	☐
10. Patients generally want reassurance rather than information about their health	☐	☐	☐	☐	☐	☐
11. If a doctor's primary tools are being open and warm, the doctor will not have a great deal of success	☐	☐	☐	☐	☐	☐
12. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	☐	☐	☐	☐	☐	☐
13. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	☐	☐	☐	☐	☐	☐
14. Most patients want to get in and out of the doctor's office as quickly as possible	☐	☐	☐	☐	☐	☐
15. The patient must always be aware that the doctor is in charge	☐	☐	☐	☐	☐	☐
16. It is not that important to know a patient's culture and background in order to treat the person's illness	☐	☐	☐	☐	☐	☐
17. Humour is a major ingredient in the doctor's treatment of the patient	☐	☐	☐	☐	☐	☐
18. When patients look up medical information on their own, this usually confuses more than it helps	☐	☐	☐	☐	☐	☐

C. Adapting to life in the UK

Living in a different culture often involves learning new skills and behaviours. Thinking about life in the UK, please rate your competence at each the following behaviours (please circle).

	1 = not at all competent				5 = extremely competent
1. Building and maintaining relationships	1	2	3	4	5
2. Managing my academic/work responsibilities	1	2	3	4	5
3. Interacting at social events	1	2	3	4	5
4. Maintaining my hobbies and interests	1	2	3	4	5
5. Adapting to the noise level in my neighbourhood	1	2	3	4	5
6. Accurately interpreting and responding to other people's gestures and facial expressions	1	2	3	4	5
7. Working effectively with other trainees/work colleagues	1	2	3	4	5
8. Obtaining community services I require	1	2	3	4	5
9. Adapting to the population density	1	2	3	4	5
10. Understanding and speaking English	1	2	3	4	5
11. Varying the rate of my speaking in a culturally appropriate manner	1	2	3	4	5
12. Gaining feedback from other trainees/work colleagues to help improve my performance	1	2	3	4	5
13. Accurately interpreting and responding to other people's emotions	1	2	3	4	5
14. Attending or participating in community activities	1	2	3	4	5
15. Finding my way around	1	2	3	4	5
16. Interacting with members of the opposite sex	1	2	3	4	5
17. Expressing my ideas to other trainees/work colleagues in a culturally appropriate manner.	1	2	3	4	5
18. Dealing with the bureaucracy (system/procedures)	1	2	3	4	5
19. Adapting to the pace of life	1	2	3	4	5
20. Reading and writing English	1	2	3	4	5
21. Changing my behaviour to suit social norms, rules, attitudes, beliefs, and customs	1	2	3	4	5

D. Communication Skills

Below is a list of tasks that you may face when practicing. Please indicate how certain you are that you can successfully perform each of the following tasks (please circle).

	1 = Very uncertain				5 = Very certain
1. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
2. Conclude a consultation with a summary of the problems and a treatment plan	1	2	3	4	5
3. Assess symptoms of anxiety and depression	1	2	3	4	5
4. Communicate bad news to a patient	1	2	3	4	5
5. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
6. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
7. Encourage a patient to describe his/her feelings	1	2	3	4	5
8. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
9. Help a patient cope with an uncertain situation	1	2	3	4	5

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please return to Amelia Kehoe (amelia.kehoe@durham.ac.uk) upon completion

Durham University
School of Medicine, Pharmacy and Health

Post-programme questionnaire

Questionnaire for NHS Staff

Please complete the questionnaire as fully as possible and return to the researcher

Your responses will remain wholly confidential to the researcher. Only aggregated responses will be presented to the NHS Trust or appear in publications.

If you have any questions please contact Amelia Kehoe (amelia.kehoe@durham.ac.uk)

ID CODE: .....

1. **What have you gained from this programme?**

2. **How will you use the skills learnt in the programme to aid in future practice?**

3. **Would you take part in further training if it was offered to you? Yes/No (please circle)**

4. **What further training would help with your adjustment to the UK?**

5. **What sessions were most useful in the programme? Please state, giving as much detail as possible.**

6. **What sessions were least useful in the programme? Please state, giving as much detail as possible.**

7. Was the programme relevant to your needs? Yes/No (please circle)

8. How could the programme be improved in the future? (Think about deliverance, duration, content etc.)

9. Do you feel that you are now more aware of your learning needs for future practice? Yes/No (please circle)

10. Reflecting back to your level of understanding at the beginning of the programme, do you feel that you are now more prepared for practice in the NHS? Yes/No (please circle)

11. Do you feel that you are receiving adequate support from the Trust? Yes/No (please circle)

12. Do you feel that you are receiving adequate support from colleagues? Yes/No (please circle)

13. Do you currently feel you are a valued member of the trust in which you are working? Yes/No (please circle)

14. Has the programme resulted in relationships being established between yourself and colleagues? Yes/No (please circle)

15. What further ongoing support would be helpful after this programme? (e.g. buddying/mentors/peer support)

16. How useful was the feedback that you received throughout?

17. What goals/targets will you set yourself as a result of this programme? (e.g. further professional development)

A. Your views on patients

The list below shows 18 statements concerning the patient-doctor relationship within the NHS. Please indicate to which extent you agree with each of the following statements (please tick).

	Strongly Agree	Somewhat Agree	Agree	Disagree	Somewhat Disagree	Strongly Disagree
1. The doctor is the one who should decide what is talked about during a visit	☐	☐	☐	☐	☐	☐
2. Although health care is less personal these days, this is a small price to pay for medical advance	☐	☐	☐	☐	☐	☐
3. The most important part of the standard medical visit is the physical examination	☐	☐	☐	☐	☐	☐
4. It is often best for patients if they do not have a full explanation of their medical condition	☐	☐	☐	☐	☐	☐
5. Patients should rely on their doctors' knowledge and not try to find out about their conditions on their own	☐	☐	☐	☐	☐	☐
6. When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters	☐	☐	☐	☐	☐	☐
7. If doctors are truly good at diagnosis and treatment, the way they relate to patients is not that important	☐	☐	☐	☐	☐	☐
8. Many patients continue asking questions even though they are not learning anything new	☐	☐	☐	☐	☐	☐
9. Patients should be treated as if they were partners with the doctor, equal in power and status.	☐	☐	☐	☐	☐	☐
10. Patients generally want reassurance rather than information about their health	☐	☐	☐	☐	☐	☐
11. If a doctor's primary tools are being open and warm, the doctor will not have a great deal of success	☐	☐	☐	☐	☐	☐
12. When patients disagree with their doctor, this is a sign that the doctor does not have the patient's respect and trust	☐	☐	☐	☐	☐	☐
13. A treatment plan cannot succeed if it is in conflict with a patient's lifestyle or values	☐	☐	☐	☐	☐	☐
14. Most patients want to get in and out of the doctor's office as quickly as possible	☐	☐	☐	☐	☐	☐
15. The patient must always be aware that the doctor is in charge	☐	☐	☐	☐	☐	☐
16. It is not that important to know a patient's culture and background in order to treat the person's illness	☐	☐	☐	☐	☐	☐
17. Humour is a major ingredient in the doctor's treatment of the patient	☐	☐	☐	☐	☐	☐
18. When patients look up medical information on their own, this usually confuses more than it helps	☐	☐	☐	☐	☐	☐

B. Adapting to life in the UK

Living in a different culture often involves learning new skills and behaviours. Thinking about life in the UK, please rate your competence at each the following behaviours (please circle).

	1 = not at all competent				5 = extremely competent
1. Building and maintaining relationships	1	2	3	4	5
2. Managing my academic/work responsibilities	1	2	3	4	5
3. Interacting at social events	1	2	3	4	5
4. Maintaining my hobbies and interests	1	2	3	4	5
5. Adapting to the noise level in my neighbourhood	1	2	3	4	5
6. Accurately interpreting and responding to other people's gestures and facial expressions	1	2	3	4	5
7. Working effectively with other trainees/work colleagues	1	2	3	4	5
8. Obtaining community services I require	1	2	3	4	5
9. Adapting to the population density	1	2	3	4	5
10. Understanding and speaking English	1	2	3	4	5
11. Varying the rate of my speaking in a culturally appropriate manner	1	2	3	4	5
12. Gaining feedback from other trainees/work colleagues to help improve my performance	1	2	3	4	5
13. Accurately interpreting and responding to other people's emotions	1	2	3	4	5
14. Attending or participating in community activities	1	2	3	4	5
15. Finding my way around	1	2	3	4	5
16. Interacting with members of the opposite sex	1	2	3	4	5
17. Expressing my ideas to other trainees/work colleagues in a culturally appropriate manner.	1	2	3	4	5
18. Dealing with the bureaucracy (system/procedures)	1	2	3	4	5
19. Adapting to the pace of life	1	2	3	4	5
20. Reading and writing English	1	2	3	4	5
21. Changing my behaviour to suit social norms, rules, attitudes, beliefs, and customs	1	2	3	4	5

C. Communication Self-Skills

Below is a list of tasks that you may face when practicing. Please indicate how certain you are that you can successfully perform each of the following tasks (please circle).

	1 = Very uncertain				5 = Very certain
1. Initiate a conversation with a patient regarding his/her worries	1	2	3	4	5
2. Conclude a consultation with a summary of the problems and a treatment plan	1	2	3	4	5
3. Assess symptoms of anxiety and depression	1	2	3	4	5
4. Communicate bad news to a patient	1	2	3	4	5
5. Confront in an appropriate manner a patient who denies his/her illness	1	2	3	4	5
6. Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor	1	2	3	4	5
7. Encourage a patient to describe his/her feelings	1	2	3	4	5
8. Explore intense emotions, such as anger, in a patient	1	2	3	4	5
9. Help a patient cope with an uncertain situation	1	2	3	4	5

How much do you agree? (please tick)	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1) I am happy to have been given the chance to learn more about NHS good practice	☐	☐	☐	☐	☐
2) I am motivated to improve my current practice	☐	☐	☐	☐	☐
3) I am aware of my strengths in practice	☐	☐	☐	☐	☐
4) I am aware of my weaknesses in practice	☐	☐	☐	☐	☐
5) Self-reflection is critical for continual improvement	☐	☐	☐	☐	☐
6) Feedback is essential to help my development	☐	☐	☐	☐	☐
7) I am fully aware of what is expected of me within the NHS	☐	☐	☐	☐	☐

8) I am confident in my knowledge of guidelines that I must follow to ensure good practice	☐	☐	☐	☐	☐
9) I am confident in my ability to manage cultural differences that may occur in practice	☐	☐	☐	☐	☐
10) I am confident that I understand the structure and hierarchy of the NHS	☐	☐	☐	☐	☐
11) I am confident that I would be able to deal with a safeguarding issue (such as a patient suffering from abuse) effectively	☐	☐	☐	☐	☐
12) I am confident in my history taking, summarising and handover abilities	☐	☐	☐	☐	☐
13) I am confident that I can work as a member of a Multidisciplinary Team	☐	☐	☐	☐	☐
14) I am confident in my understanding of protocols to follow involving informed consent and confidentiality	☐	☐	☐	☐	☐
15) I am confident that I can manage an acute situation	☐	☐	☐	☐	☐
20) I am confident that I would be able to manage a situation involving error	☐	☐	☐	☐	☐

THANK YOU FOR COMPLETING THIS EVALUATION

Please return to Amelia Kehoe (amelia.kehoe@durham.ac.uk) upon completion.

George's Patient Safety in Simulation tool (GPSS) (SELF ASSESSMENT)

ID CODE: .....

Please read each of the statements below. For each of the skills (A-F), please tick ***ONE*** of the statements that you feel best represent your performance. Each of the three statements represents satisfactory, borderline or unsatisfactory performance.

1. Developing critical thinking and clinical decision making skills

Satisfactory	Borderline	Unsatisfactory
A. Takes a thorough focussed history to identify problem	*A.* Takes a detailed though unfocussed history	*A.* Takes an unfocussed, unclear history
B. Correctly interprets all important clinical signs	*B.* Correctly interprets some important clinical signs	*B.* Fails to correctly interpret important clinical signs
C. Independently requests all appropriate key investigations	*C.* Requests most appropriate key investigations with prompting	*C.* Does not request most appropriate key investigations without prompting
D. Formulates a reasonable differential diagnosis including the correct diagnosis	*D.* Formulates a reasonable differential diagnosis but does not include the correct diagnosis	*D.* Does not formulate a reasonable differential diagnosis
E. Recognises critical illness and responds with due urgency	*E.* Recognises critical illness and responds but without priority	*E.* Fails to recognise critical illness or respond with due urgency
F. Institutes correct management and effective interventions to abnormal physiology e.g. fluid resuscitation, NIV	*F.* Institutes mostly correct management and some effective interventions to abnormal physiology e.g. fluid resuscitation, NIV	*F.* Does not institute correct management or effective interventions to abnormal physiology e.g. fluid resuscitation, NIV

2. Preventing medication errors

Satisfactory	Borderline	Unsatisfactory
A. Positively verifies patient's current medication list	*A.* Attempts to verify patient's current medication list	*A.* Fails to verify patient's current medication list
B. Checks for drug allergies with patient if not relative or GP	*B.* Attempts to check for drug allergies	*B.* Does not check at all for drug allergies
C. Correctly prescribes all appropriate drug therapy particularly fluids, analgesia, antipyretics or antibiotics via correct route	*C.* Prescribes some appropriate drug therapy including fluids, analgesia, antipyretics or antibiotics via correct route	*C.* Fails to prescribe appropriate drug therapy particularly fluids, analgesia, antipyretics or antibiotics via correct route
D. Modifies/stops all necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function	*D.* Modifies/stops only some necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function	*D.* Does not modify/stop any necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function
E. Highlights prescriptions to nursing staff and ensures timely administration	*E.* Highlights prescriptions to nursing staff but does not ensure timely administration	*E.* Fails to highlight prescriptions to nursing staff or ensure timely administration
F. Clearly explains benefits and side effects of medication to patient	*F.* Attempts to explain benefits and/or side effects of medication to patient	*F.* Does not explain benefits and/or side effects of any medication to patient

3. Promoting effective communication

Satisfactory	Borderline	Unsatisfactory
A. Introduces self to patient and staff and asks for names of team in return	*A.* Introduces self to patient but not staff	*A.* Does not properly introduce self to patient or staff and fails to verify their names in return
B. Asks relevant, clear questions to patient	*B.* Asks clear questions to patient though not always relevant	*B.* Does not ask relevant or clear questions to patient
C. Provides good reassurance and support to patient	*C.* Provides some reassurance and support to patient	*C.* Fails to offer reassurance or support to patient
D. Gives clear and appropriate instructions to staff	*D.* Gives appropriate instructions to staff though sometimes unclear	*D.* Fails to give clear or appropriate instructions to staff
E. Seeks appropriate senior/specialist input in a timely manner	*E.* Seeks senior/specialist input though not in a timely manner	*E.* Fails to seek appropriate senior/specialist input in a timely manner
F. Actions good handover/description of problems in escalation using SBAR	*F.* Good description of problems in escalation but does not use SBAR	*F.* Poor handover/incomplete description of problems in escalation without SBAR

4. Encouraging teamwork

Satisfactory	Borderline	Unsatisfactory
A. Gains full appropriate support from nursing colleagues and available team	*A.* Gains some support from nursing colleagues and available team	*A.* Does not gain appropriate support from nursing colleagues and available team
B. Fully supports nurse and junior team members keeping them on course	*B.* Supports nurse and junior team members but does not keep track of their activity	*B.* Does not appear to acknowledge or support nurse and junior team members
C. Demonstrates effective prioritisation of tasks throughout	*C.* Demonstrates some prioritisation of tasks though not organised	*C.* Fails to prioritise tasks effectively
D. Exhibits fully appropriate delegation of tasks	*D.* Exhibits some delegation of tasks though not organised	*D.* Fails to delegate tasks appropriately
E. Keeps team in the loop by vocalising thought processes throughout	*E.* Occasionally vocalises thought processes to team	*E.* Does not vocalise thought processes to team at all
F. Invites contribution from all other team members including nurse	*F.* Invites contribution from some but not all team members	*F.* Does not invite any contribution from other team members including nurse

Total Score ..... (Tick values: 2 points = satisfactory, 1 point = borderline, 0 point = unsatisfactory)

George's Patient Safety in Simulation tool (GPSS) (OBSERVER)

ID CODE: .....

Please read the statements below. For each of the skills (A-F), please tick ***ONE*** of the statements that you feel best represent the performance of the individual that you are observing. Each of the three statements represents satisfactory, borderline or unsatisfactory performance.

1. Developing critical thinking and clinical decision making skills

Satisfactory	Borderline	Unsatisfactory
A. Takes a thorough focussed history to identify problem	*A.* Takes a detailed though unfocussed history	*A.* Takes an unfocussed, unclear history
B. Correctly interprets all important clinical signs	*B.* Correctly interprets some important clinical signs	*B.* Fails to correctly interpret important clinical signs
C. Independently requests all appropriate key investigations	*C.* Requests most appropriate key investigations with prompting	*C.* Does not request most appropriate key investigations without prompting
D. Formulates a reasonable differential diagnosis including the correct diagnosis	*D.* Formulates a reasonable differential diagnosis but does not include the correct diagnosis	*D.* Does not formulate a reasonable differential diagnosis
E. Recognises critical illness and responds with due urgency	*E.* Recognises critical illness and responds but without priority	*E.* Fails to recognise critical illness or respond with due urgency
F. Institutes correct management and effective interventions to abnormal physiology e.g. fluid resuscitation, NIV	*F.* Institutes mostly correct management and some effective interventions to abnormal physiology e.g. fluid resuscitation, NIV	*F.* Does not institute correct management or effective interventions to abnormal physiology e.g. fluid resuscitation, NIV

2. Preventing medication errors

Satisfactory	Borderline	Unsatisfactory
A. Positively verifies patient's current medication list	*A.* Attempts to verify patient's current medication list	*A.* Fails to verify patient's current medication list
B. Checks for drug allergies with patient if not relative or GP	*B.* Attempts to check for drug allergies	*B.* Does not check at all for drug allergies
C. Correctly prescribes all appropriate drug therapy particularly fluids, analgesia, antipyretics or antibiotics via correct route	*C.* Prescribes some appropriate drug therapy including fluids, analgesia, antipyretics or antibiotics via correct route	*C.* Fails to prescribe appropriate drug therapy particularly fluids, analgesia, antipyretics or antibiotics via correct route
D. Modifies/stops all necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function	*D.* Modifies/stops only some necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function	*D.* Does not modify/stop any necessary contraindicated medication e.g. NSAIDS, Ace inhibitors etc. in deteriorating renal function
E. Highlights prescriptions to nursing staff and ensures timely administration	*E.* Highlights prescriptions to nursing staff but does not ensure timely administration	*E.* Fails to highlight prescriptions to nursing staff or ensure timely administration
F. Clearly explains benefits and side effects of medication to patient	*F.* Attempts to explain benefits and/or side effects of medication to patient	*F.* Does not explain benefits and/or side effects of any medication to patient

3. Promoting effective communication

Satisfactory	Borderline	Unsatisfactory
A. Introduces self to patient and staff and asks for names of team in return	*A.* Introduces self to patient but not staff	*A.* Does not properly introduce self to patient or staff and fails to verify their names in return
B. Asks relevant, clear questions to patient	*B.* Asks clear questions to patient though not always relevant	*B.* Does not ask relevant or clear questions to patient
C. Provides good reassurance and support to patient	*C.* Provides some reassurance and support to patient	*C.* Fails to offer reassurance or support to patient
D. Gives clear and appropriate instructions to staff	*D.* Gives appropriate instructions to staff though sometimes unclear	*D.* Fails to give clear or appropriate instructions to staff
E. Seeks appropriate senior/specialist input in a timely manner	*E.* Seeks senior/specialist input though not in a timely manner	*E.* Fails to seek appropriate senior/specialist input in a timely manner
F. Actions good handover/description of problems in escalation using SBAR	*F.* Good description of problems in escalation but does not use SBAR	*F.* Poor handover/incomplete description of problems in escalation without SBAR

4. Encouraging teamwork

Satisfactory	Borderline	Unsatisfactory
A. Gains full appropriate support from nursing colleagues and available team	*A.* Gains some support from nursing colleagues and available team	*A.* Does not gain appropriate support from nursing colleagues and available team
B. Fully supports nurse and junior team members keeping them on course	*B.* Supports nurse and junior team members but does not keep track of their activity	*B.* Does not appear to acknowledge or support nurse and junior team members
C. Demonstrates effective prioritisation of tasks throughout	*C.* Demonstrates some prioritisation of tasks though not organised	*C.* Fails to prioritise tasks effectively
D. Exhibits fully appropriate delegation of tasks	*D.* Exhibits some delegation of tasks though not organised	*D.* Fails to delegate tasks appropriately
E. Keeps team in the loop by vocalising thought processes throughout	*E.* Occasionally vocalises thought processes to team	*E.* Does not vocalise thought processes to team at all
F. Invites contribution from all other team members including nurse	*F.* Invites contribution from some but not all team members	*F.* Does not invite any contribution from other team members including nurse

Total Score ..... (Tick values: 2 points = satisfactory, 1 point = borderline, 0 point = unsatisfactory)

PNCI® Simulation Effectiveness Tool

ID CODE: ……

Please reflect on the simulation training that you have taken part in.

Please rate the following statements on the scale provided. Mark NA if you have no experience with the statement.

	Do not agree	Somewhat agree	Strongly Agree	Not Applicable
The feedback helped me to think critically	0	1	2	NA
I feel better prepared to care for real patients	0	1	2	NA
I developed a better understanding of the conditions in the scenario	0	1	2	NA
I developed a better understanding of the medications that were in the scenario	0	1	2	NA
I feel more confident in my decision-making skills	0	1	2	NA
I am more confident in determining how to handover information to others	0	1	2	NA
My assessment skills improved	0	1	2	NA
I feel more confident that I will be able to recognise changes in my real patient's condition	0	1	2	NA
I am able to better predict what changes may occur with my real patients	0	1	2	NA
Completing the scenario helped me understand learnt medical information	0	1	2	NA
I was challenged in my thinking and decision-making skills	0	1	2	NA
I learned as much from observing my peers as I did when I was actively involved in caring for the simulated patient	0	1	2	NA
Debriefing and group discussion were valuable	0	1	2	NA

Comments:

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Supporting international medical graduates' transition to their host-country: realist synthesis

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CONTEXT Many health services and systems rely on the contribution of international medical graduates (IMGs) to the workforce. However, concern has grown around their regulation and professional practice. There is a need, in the absence of strong evidence and a robust theoretical base, for a deeper understanding of the efficacy of interventions used to support IMGs' transition to their host countries. This study seeks to explore and synthesise evidence relating to interventions developed for IMGs. It aims to provide educators and policy makers with an understanding of how interventions should be developed to support IMGs in their transition to the workplace, particularly looking to identify how and why they are effective.

METHODS The realist synthesis involved an initial systematic search of the literature for the period January 1990 to April 2015. Secondary searches were conducted throughout the review in order to inform and test the developing programme theory. The context, mechanism and outcome data were extracted from all sources meeting the inclusion criteria. Fourteen case studies were included to further aid theory refinement.

RESULTS Sixty-two articles were identified, describing diverse interventions of varying intensity. A further 26 articles were identified through a secondary search. The findings illustrate that, alongside a developed programme, ongoing support and cultural awareness at organisational and training levels are crucial. Individual differences must also be taken into consideration. This will ensure that IMGs engage in transformative learning, increase their levels of self-efficacy and cultural health capital, and reduce feelings of stress and anxiety. These factors will have an impact on work, interactions and cultural adjustment.

CONCLUSIONS Organisational, training and individual contexts all play a role in IMGs' adjustment during the transition process. Establishing ongoing support is critical. A list of recommendations for implementation is given.

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INTRODUCTION

International medical graduates (IMGs), those who have gained their primary medical qualifications in countries outside of the host country in which they work, have been playing an increasingly crucial role over recent years in ensuring effective delivery of health care.[1] For example, in the UK, more than a third of registered doctors have gained their medical qualification outside the UK.[2] This number has risen since 2014, with a particular increase in European medical graduates applying for registration.[1]

Concern has grown around the regulation and professional practice of those who qualified outside the host country. Research suggests that IMGs are likely to face difficulties with communication, culture, practical issues, team working and hierarchical structures,[3] which in turn may lead to a greater risk of referral for fitness to practice.[4]

Although research has led to recommendations concerning the transition of IMGs,[5–8] the area is underdeveloped. Existing interventions, such as induction programmes and communication skills courses, are currently being implemented,[8] often at a regional rather than organisational level. For example, half-day programmes are often implemented without sufficient consideration of what is likely to work or how much training is appropriate. Combined with the probability that educators do not have specific experience with the particular needs of IMGs,[9–11] this can pose a problem for those involved in developing interventions to support the transition of IMGs.

Research is needed to provide guidance on the most effective ways to implement IMGs' transition to their new work environments, both theoretically and empirically.[8,12] Another issue to recognise is that doctors in different stages of transition will face different problems and different training needs.[13] For example, the initial move to a host country can cause culture shock and difficulties in cross-cultural adjustment. Once an individual has been living in the country for some time, however, they are likely to have developed personal resources, social supports and adequate coping strategies. Employers should understand the needs of their IMGs in order to support them.[14] The induction of IMGs needs to be an ongoing, iterative process of learning that continues throughout training, perhaps through 'buddying' or peer support.[5,14]

If resources are to be invested in ongoing, rigorous interventions, it is important to understand what interventions work within a given context and what produces the desired outcome. A recent systematic review on this subject recommended an exploration of theory and evidence in a search of educational interventions for IMGs.[8] These processes of effective transition at the workplace level have, up until now, been taken for granted.[1]

This synthesis describes these interventions using a realist approach.[15] It enables interventions to be fully explored, through theoretical considerations and synthesis of evidence, so that details of interventions are explored in depth to enhance understanding about why interventions work, or not, and what is likely to be effective if implemented elsewhere.

Although the focus of this synthesis is on medical graduates, graduates from other health care professions have not been excluded from the analysis. Lessons learned from looking at common forms of intervention across the health care professions can help us to further understand the conditions in which the interventions trigger differing mechanisms to generate both wanted and unwanted outcomes.[16]

METHODS

The aim of this synthesis was to explore and synthesise evidence relating to interventions developed to enable IMGs to make a successful transition to the workplace. The research aims were (i) to identify what interventions have been used to support the transition of IMGs to the workplace, (ii) to identify how and why they are effective, (iii) to identify what factors are important to achieve a successful transition and (iv) to identify the theory that explains why interventions are successful and supports wider future interventions.

Design

Realist synthesis is a 'systematic, theory-driven interpretative technique'[17] that has emerged as a strategy for synthesising evidence and providing explanations (programme theories) on why interventions may, or may not, work (i.e. how and in what circumstances). It allows interrogation of evidence from primary and secondary data sources on the contextual factors that affect successful intervention and describes the mechanisms that lead to successful intervention.[18] Mechanisms are processes operating

within an intervention that illustrate the way in which available resources are used.[15] Key components of intervention and exploration of the context–mechanism–outcome configurations (CMOCs) were incorporated into the developing programme theory.

Realist And MEta-narrative Evidence Syntheses: Evolving Standards (RAMESES) quality standards were used to guide the method.[19]

Initial programme theory

Realist synthesis involves the extraction of theories from a dataset to explain the influence of a certain context on a mechanism that is being used to produce an outcome. This synthesis sought to extract theories that would explain how interventions support the transition of IMGs to the workplace. Initial theory formulation was achieved through searching relevant IMG literature, policy documents, face-to-face discussions with stakeholders (clinical directors from various Trusts) and discussions within the research team, who were familiar with both IMG and transition literature. Kirwan and Birchall's transfer of learning model[20] was identified as being central to the development of initial programme theories that facilitated exploration of the concepts identified in this synthesis. The model places much emphasis on the motivation to transfer and indicates many of the elements that appear to be crucial to IMG transition. The model was also identified as being clear and applicable to the realist approach, allowing for analysis at three levels: the individual (the learner), the education or training intervention and the work environment. The focus of this synthesis was therefore on three similar contextual levels (individual, training and organisational). The transitional outcomes were based on Harrison and Shaffer's Adjustment–Effort–Performance Model.[13] They propose three elements of transition: cultural adjustment (process of acculturation and overcoming culture shock, also associated with non-work factors), work adjustment (performance and feeling comfortable with the job) and interaction adjustment (being comfortable with interactions with host-country nationals). These three areas are also evident in research into transition between health care contexts.[21] Like the transfer of learning model, it too looks at individual and organisational factors that influence job performance. These initial programme theories were used to guide data extraction and ensure the identification of relevant data. The theories were not intended to restrict theory development, but to trigger concepts and test and refine developing theory. Terms were also agreed upon at this stage to guide the synthesis and data extraction.

Data sources and search

With the help of an information scientist, an initial systematic search was conducted to identify relevant evidence. The databases searched included Medline, PsycINFO, EMBASE and Educational Resource Information Centre (ERIC). The same key words were used across all databases relating to the target population (e.g. *overseas doctor* OR International Medical Graduate**) and interventions (e.g. *support OR induction*) (see Appendix S1 for full list). It was decided that analysis would be enriched by the inclusion of grey literature, descriptive studies and theoretical papers. The results were filtered by title and then abstract by the first author. A random sample (10%) was selected and assessed by the research team to ensure quality assurance.[19] Papers were then coded for rigour and relevance,[19] and key findings and themes highlighted.

Titles and abstracts were considered against the inclusion and exclusion criteria, reflecting development of the initial programme theory (see Appendix S2), and duplicates were removed. Contact was made with authors via e-mail to retrieve evaluations that had been referred to in the article but not published, or when further information was required.

Data analysis and synthesis

Data were extracted from each study using a template that included study information, CMOCs, relevant theory, and an assessment of relevance and rigour. Relevance and rigour were assessed on a scale of 1–5 for each paper (see Appendix S3). Articles low on relevance and rigour (i.e. scored 2 or less) were generally excluded. However, descriptive pieces that provided rich data and added to theory development (high on relevance but low on rigour) were included.[19] On occasions outcomes were implied from the mechanisms highlighted rather than explicitly stated. Extracted CMOCs were inputted into an Excel spread sheet for further analysis. Data synthesis included further refinement of the CMOCs and the generating of hypotheses. Results were extensively shared and reviewed with key stakeholders (clinical directors and policy makers), programme planning teams from health care organisations, IMGs, educators, UK doctors, educational directors and tutors. Discussions took place concerning issues such as competing theories. Real-

ist experts from RAMESES were contacted at appropriate times to provide guidance on the realist methodology, developing CMOCs and developing theory.

Interventions were identified at the synthesis stage, from grey literature and hand searching (primarily within the UK), and were developed into case studies to aid theory refinement (a 'reality check'). The case studies enabled further exploration of inconsistencies to test programme theories and ensure maximum variation. Discussions were held with IMGs and those involved in programme development and implementation.

The basic task of the synthesis process was to refine the programme theory[15] (searches being iterative, not sequential).[19] As new elements of theory were developed from the data, secondary searches for evidence to support and refine those elements were required. The research team discussed the CMOCs to develop the overarching theory.

RESULTS

The initial search yielded 4124 results. Figure 1 illustrates the filtering process, which resulted in 62 papers being included.

The interventions included communication and linguistic skills courses, acculturation courses, examination workshops, cultural and social skills workshops, shadowing, bridging programmes, pre-employment programmes, inductions, orientations, buddying programmes, peer support, supervised practice, 'observerships', simulation and web-based resources. The articles found were from Australia, Canada, the USA and the UK. Of the 62 papers, 48 reported on doctors and 13 on nurses who graduated outside of the host country. One addressed physiotherapists. The duration of these interventions ranged from a 1-day course (5 hours) to 3 years of training. The majority of the interventions were implemented across a number of weeks or months and included a variety of components and levels of support. All but one of the 62 papers offered ongoing support in some way, whether through support groups, buddies or ongoing training. Many regarded successful interventions to be between 3 and 5 days in length.[22] Different kinds of transition (e.g. social and work) were generally addressed separately. The interventions focused on differing stages of transition: prior to starting work, beginning practice, and ongoing throughout employment.

Although some papers were based on rigorous evaluations of the interventions, others were merely descriptive (16 papers) and reported no outcome data. Others were small scale ($n \leq 15$) or focused on one intervention in a single setting. Both qualitative and quantitative methodologies were used, the majority consisting of self-assessment tests before and after interventions.

As the theory developed, new areas of interest emerged and were explored further in secondary searches.[19] Twenty-six articles were included from secondary searches and interventions included buddying, simulation and web-based programmes. Saturation was reached at this point as no other themes were identified to support theory development and refinement.[19]

Fourteen case studies were included in this synthesis. Each case study (CS) has been numbered and details of their duration are presented in Table 1. Interventions developed in the UK have generally been delivered over 1 day (or less). One exception was CS1, which was developed as a 5-day programme. The three case studies from outside the UK offered ongoing support. Those from the UK largely lacked ongoing support. The case studies relied on participant feedback, but failed to evaluate the interventions independently. All but one of the interventions were aimed at doctors.

Refined programme theory

The presentations of findings from this synthesis are framed around the three contextual levels derived from the refined programme theory (Fig. 2). The three levels (organisational, training and individual) will be described in detail, highlighting how the differing contextual factors (c) may facilitate or hinder transition, by referring to the relevant mechanisms (m) and outcomes (o).

Most of the primary outcomes found in this synthesis are related to work adjustment, such as performance,[23–35] patient safety,[36] quality of care and patient satisfaction,[25,26] retention,[25,37–41] staff satisfaction,[42,43] passing of assessments and registration,[44–47] and employment.[16,34,42,47,48] Outcomes in terms of adjustment to life in a new country are not generally focused on, although cultural awareness was reported.[49] Adjustment within interactions may occur through specific communication skills training and interaction with colleagues.[23,30] Cultural adjustment was largely addressed through training and the development of support networks.[28,49]

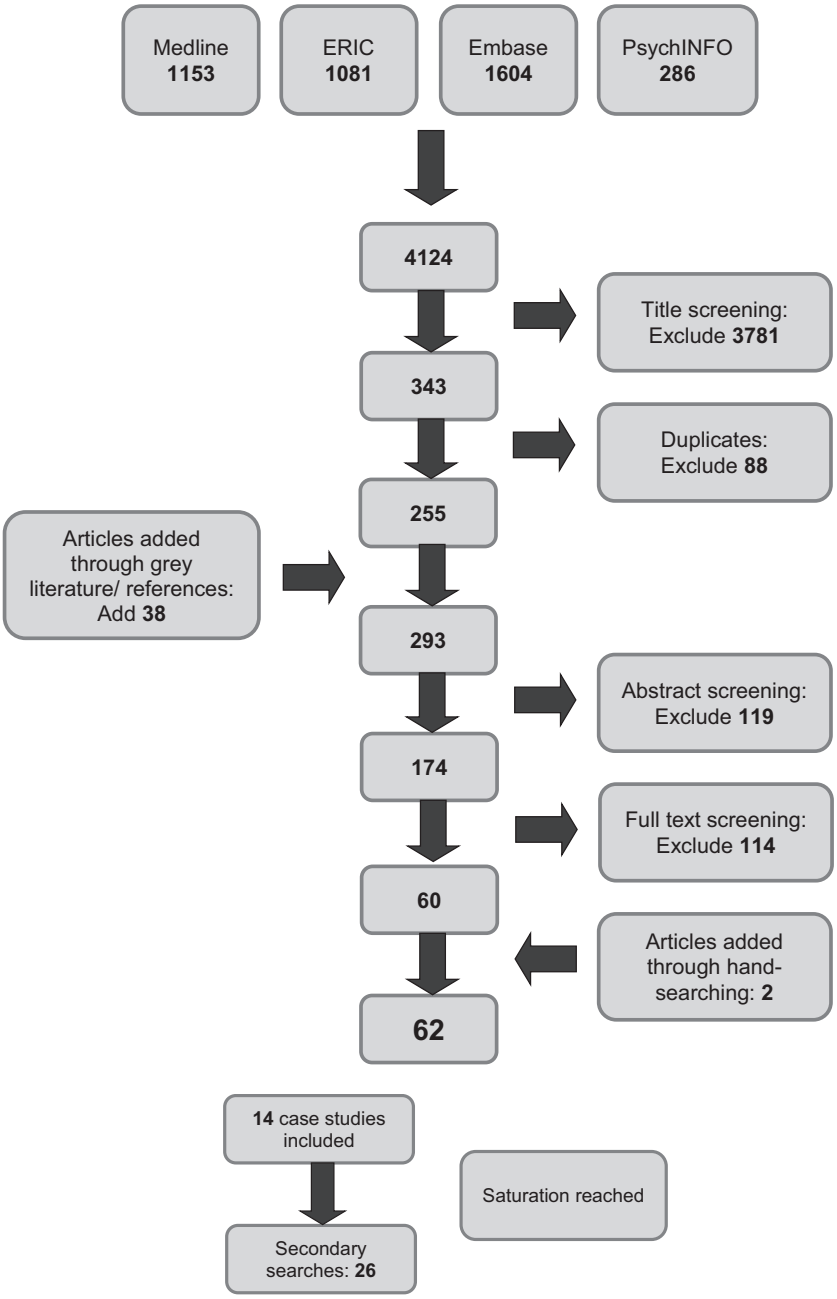

Figure 1 Diagram of search results

Organisational contextual factors

Organisational culture

The need for intercultural awareness within an organisation is essential (c),[5,9,16,23,26,34,45,50–53] as IMGs arrive with differing cultural experiences and expectations that can have an impact on both learning and practice.[46] Organisations need to understand how IMGs are coping and accept that this group may have vulnerabilities, and handle this sensitively without being patronising or creating a sense of stigma (c) (CS1). IMGs may only engage with (m) and be motivated to transfer what they have learned (m) in the programme if there is a sense of acceptance from colleagues[37] (CS1). This will have an impact on both professional development and performance (o).

Organisations must take responsibility and be responsive to the needs of both IMGs and their institution[5,12,16,32,34,37,41,42,44,47,48,50,54–74]

Table 1 Case study characteristics

Case study	Organisation	Year	Duration	Intervention
1	University Hospital of North Tees	2013	5 days	Enhanced Shadowing Programme (POD) (Pilot 1)
2	University Hospital of North Tees	2014	2 days	Programme for overseas Doctors (POD) (Pilot 2)
3	University Hospital of North Tees	2014	2 days	Programme for overseas Doctors (POD) (Pilot 3)
4	College of Physicians and Surgeons of Nova Scotia	2013	5 days	Clinician Assessment For Practice Program (CAPP)
5	Health Education North East	2010–2013	1 day	Support for overseas doctors new to clinical practice in the UK
6	Health Education North East	2014	1 day (one day follow)	Support for overseas doctors new to clinical practice in the UK
7	Registered Nurses Professional Development Centre	2012	8 sessions, 1 per week (3 hours – 6–9 pm)	Orientation to the Canadian Health Care System
8	London Deanery	2014	Online package	E-learning Induction Package for International Medical Graduates and EU doctors
9	Central Manchester University Hospital	2014	Onine/ongoing	Online induction and support system (peer 'buddy' support and educational supervisors)
10	GMC	2013	1 day	Welcome to UK Practice
11	Aukland District Health Board (ADHB)	2011	26 weeks	Ready-for-Work Training Programme
12	Yorkshire and the Humber Foundation School	2014	1 day	Induction to NHS
13	BMA	2015	Half day	Welcome to UK Practice seminar
14	Health Education North East	2015	1 day	Communication skills for Doctors new to UK Practice

(CS1-10, 13), also understanding how IMGs have previously practised (c).[72] Organisations need to hold realistic expectations and not make assumptions,[43] either that IMGs can simply move into practice without extra support[75–77] or cannot practise competently upon arrival[33] (CS1-3). Both supervisors and colleagues may benefit from cultural awareness training (c)[34,64,78,79] (CS6). IMGs need to feel confident (m) that the organisation in which they are working provides a high enough level of support, and a supportive culture leading to retention and high overall performance (o).[24,30,47,52,57]

IMGs should have the opportunity to build on their competencies, and not feel they must 'unlearn' what was previously known. A focus purely on host-country culture can be detrimental to IMGs' transition (c).[46] A lack of confidence and anxiety around stigma (m) is likely to occur if employers treat IMGs as second-rate employees.[80] Through organisational induction, support groups, reflection and ongoing evaluation of IMGs' adjustment,[22] a healthier and culturally rich learning environment can be created[80] in order for work adjustment to occur (o).

Leadership

A key individual, who thoroughly understands the needs of IMGs, will push interventions forward and will strive for organisational change, is needed (c)[12,16,23–25,32,47,52,72,74,81,82] (CS1-3, 6, 9, 11, 12). It is acknowledged that there is a lack of time, resources and commitment in many cases, but an enthusiast can increase overall organisational support (CS2, 3, 6). Organisational commitment can have an impact on how supported IMGs feel, in

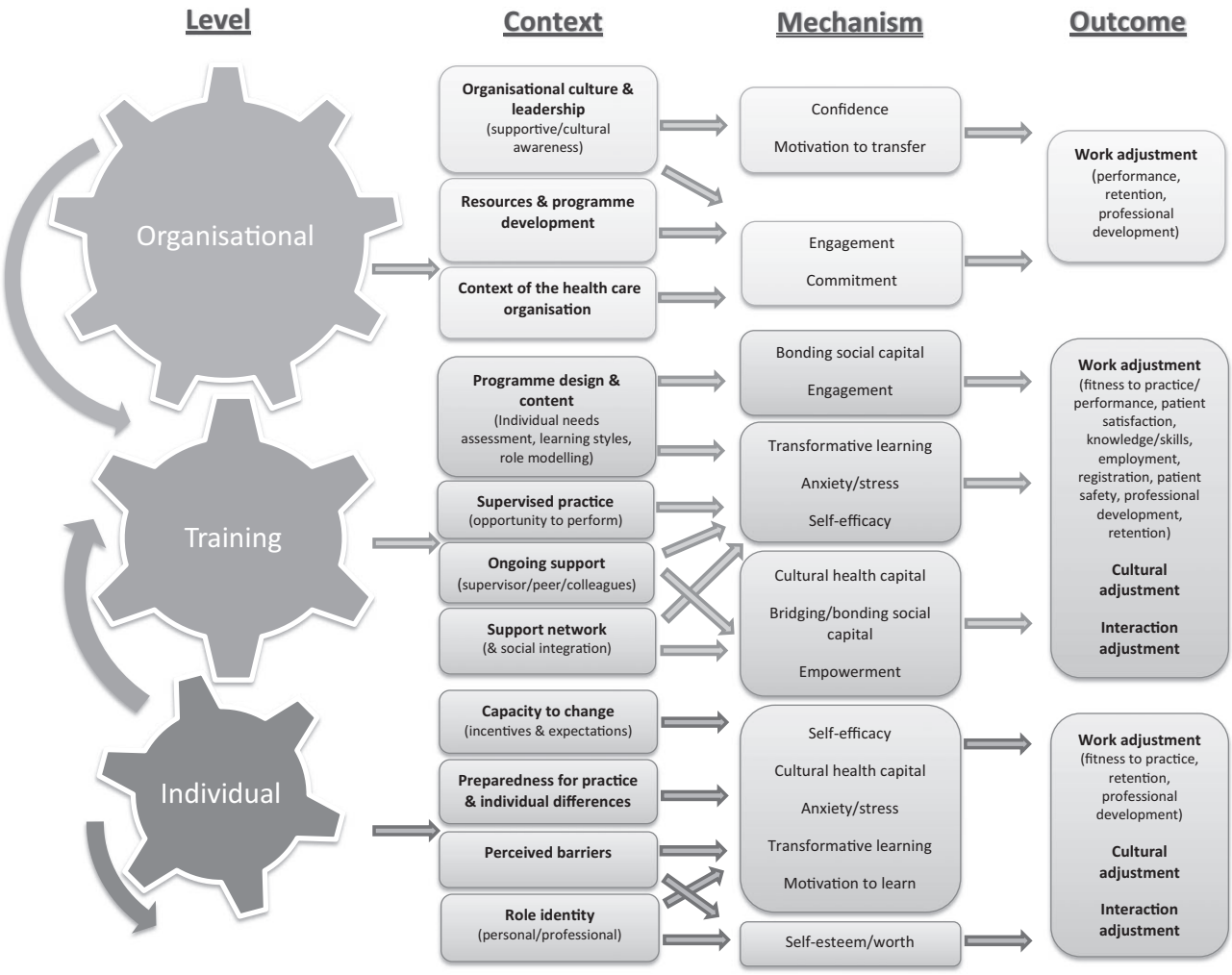

Figure 2 Refined programme theory illustrating IMG transition

turn increasing their levels of organisational commitment and their motivation to transfer their learning (m) (CS3) and therefore improve their performance (o).

Resources

The amount of resources invested into IMGs' transition will inevitably have an impact on the characteristics of the interventions offered[9,23,25,26,29,37,39,42,44,47,51,52,55,58,64,67,69,74,75,78,83–89] (CS1-4, 7–9, 11). As a result of the high cost, lack of time, practicalities and inflexibility,[24,84] ongoing support may be problematic and interventions are therefore guided by available resources (c).[54] Many failed attempts are the result of a lack of resources and time,[34,46] meaning that interventions are often implemented half-heartedly.

Thorough and comprehensive interventions are needed to aid transition.[72] Although a 1-day induction is better than nothing (CS5, 6, 10), it can be viewed as more of a 'welcome', not offering the ongoing support needed (c)[30,56,63,88,90] (CS12). Although resource intensive,[32] stakeholders need to balance improved efficacy of IMGs against the amount of work carried out.[34,57] IMGs report a preference for a longer orientation,[41] ensuring a higher level of both engagement in the acculturation process (m) (CS3) and overall benefits to adjustment (o).[54,88] Organisations should aim to draw upon local faculty members,[9,12,33,58] embedding programmes into their normal practice.

Engagement with the intervention may decrease if IMGs lack the income to support attendance.[48,59] Many need income to support the living costs of both themselves and their families[5]; therefore charging a fee to attend (c) is likely to reduce attendance (m)[42,47,79] (CS5, 6, 14). Financial and practical support, such as accommodation and transport,[22,42] has

been offered in some cases. The aim of this is to reduce the stress and financial hardship experienced by IMGs (m), although it increases the employer's costs and commitment to them.

Context of the health care organisation

The organisational context can affect the learning of IMGs[16,22,24,41,47,67–69,71,72,91] (CS9); examples including training site (e.g. rural), type of speciality and level of training (c).[78,82,91,92] Transition can be difficult if the area in which an IMG is working does not offer the necessary resources. This is likely to result in a reduction of both commitment and engagement (m), leaving IMGs more 'at risk' (o).[69] For example, rural areas may not be ethnically diverse and may not meet cultural needs, leading to feelings of isolation (m),[52] which may lead the individual to return home (o). Conversely, smaller communities may in fact provide a good transitional environment if there is a supportive atmosphere and a sense of teamwork (c).[67]

IMGs must identify with the local community (c)[5,52] and recognise the different types of patients' needs, social norms and colloquial language that may be specific to that area (m).[33,65] Such issues must be taken into consideration, ensuring that IMGs engage in the necessary training (m), for the well-being of both the IMG and the patient (o).

Programme development

Organisations often fail to implement successful interventions because of poor development (c) (CS12), thus reducing the engagement of IMGs (m), who may feel their needs have not been addressed, and leading organisations to give up. However, thorough planning, a review of the literature and theory and responsiveness to changing needs[47,70,75] will undoubtedly improve the chance of success. Programmes should not be implemented as a 'tick box' or for convenience.[52] A steering group (including IMGs and experts), a pilot programme and ongoing evaluation and development are necessary to meet the needs of IMGs (o)[9,12,16,23,24,33–35,37,41–44,46–49,53–57,59,62,64,65,67,71–74,77,79,82,86,87,89,90,93] (CS1-8, 10, 12-13).

Evidence suggests that there needs to be a better human resources (HR) process for identifying new IMGs within each organisation[12,24,34,36,41,42,45,55,57,58,62,64,71,72,77,94] (CS3, 4, 6-8, 14), to ensure appropriate support and induction is put in place as early as possible and for all who require it (c).[33] The dissemination of information in advance is crucial to the engagement of IMGs and raising awareness of potential difficulties they may face (m). Information packs sent prior to arrival in the host country may also aid adjustment to work (o),[68,93] through reducing anxiety (m), adding to perceived support and increasing initial commitment to the organisation (o).[71] These information packs can target IMGs at the earliest phase of their transition (before arrival) and capture those who start outside of normal contractual dates.[93]

Contextual factors of training: programme implementation

Individual needs assessment

The findings highlight the importance of individual needs assessment, particularly when conducted upon arrival, before any intervention is implemented (c)[2,5,23–26,28,29,33–37,42,44–48,51–55,57–60,62,65,67,68,70–72,82–84,87,89,90,93–96] (CS2-4, 7, 9). This enables training to be tailored[43,56,69] and support given where necessary (CS9). IMGs will only benefit from training that is relevant and meaningful (c).[9,22] Increased *transformative learning* (self-awareness, beliefs, behavioural) and engagement is likely to result from an initial needs assessment (m).[33,56] Organisations need to take account of the individual past experiences of IMGs within different health care systems and social and cultural contexts (c).[55] Being aware of personal learning needs enables IMGs to reflect on these in practice (m), aiding their professional development (CS9) and resulting behaviours (o).[95]

Environment and learning styles

A safe environment, which is low risk and controlled, must be created when implementing interventions for IMGs (c)[2,12,25,26,32,36,37,42,49,55,58,60,67,68,74,76,81,83–85,93,94,97–99](CS1-7, 10-11, 13). IMGs must feel able to recognise and admit mistakes and share challenges without fear, reducing anxiety both during the intervention and in practice (m).[29,49] In sharing experiences and reflecting on their own practice (c), IMGs' engagement and levels of *cultural health capital* (wellbeing, resources, resilience, optimism)[100] are likely to increase (m)[49], and they will acquire resources to use in practice (o). Self-efficacy is also likely to increase (m),[24,87,91] so that IMGs will not blame themselves and be able to acknowledge that others are facing similar difficulties. These experiences are also likely to lead to transformative learning (m),[49] which will further be enhanced through experiential learning involving

feedback and reflection.[27,46,49,56] Such learning will lead to better work adjustment (o).

Experiential learning with feedback and reflection[16,24,29,32,33,36,37,39,42,44,45,47,48,53–55,58,62–64,66–69,71,72,76,79,83,86,88,89,91,93,97,99,101] (CS1-3, 7, 11, 13), such as simulation[70,77] and role play,[102] creates active participation (c), enabling IMGs to learn through errors, problem solving and skill rehearsal[61,87] and relate these to real life practice (m).[34] Professional self-efficacy will increase (m), enabling IMGs to feel more able to apply new knowledge and skills in practice (o)[29, 87] (CS1-3). They will acquire new resources that can be used in what are potentially stressful situations (m), causing them to feel more prepared to meet the demands of practice (o).[29,77,83] Educators must be aware of differences in learning styles and learner responsiveness (c).[27,56,70]

Learning is both an individual and social experience and small group discussion and peer feedback are essential (c)[12,16,23,24,26,32,33,37,46,48,49,55–58,62,65,72,78,79,83,87–89,91,94,96,97,99,102] (CS1-3, 6, 10, 14), as they promote self-reflection and self-awareness (transformative learning) (m). Engagement is much more likely to occur in small groups than in larger groups (m)[77] once initial shyness is overcome.[62,87] Identity formation within the group is likely to occur (m) through sharing of stories and experiences[62], aiding both work and cultural adjustment (o).

Role modelling

The inclusion of role modelling is seen as important for IMGs[2,12,24,33,36,38,40,42,49,50,53,70,71,73,75,78,81,83–85,87] (CS4, 6, 7, 9, 10), as it enables them to relate to those who have faced similar issues (c).[22,60] Hearing the stories of IMGs who have been through a similar transition will raise awareness that issues faced are 'universal', reducing anxiety and increasing cultural health capital (m).[37] Seeing others succeed may also increase self-efficacy (m)[22,87] and lead to work adjustment (o).

Programme content and design

The programme content must be relevant to IMGs and reflect issues of concern to them[5,23,24,27,32,33,35,37,40–42,44,46–49,51,54,56,57,61,62,65,67,69–73,75,76,82,87,89,93,97,103] (CS1-7, 9, 13, 14), being learner focused and meeting individual needs (c)[32,56] (CS2, 3, 10). IMGs are more likely to engage with the content (m) if a rationale for learning is identified. This will then lead to increased knowledge, skills and understanding[16,23,27,30,33,35,44–46,48,49,56,57,59,66,67,70,73,79,89] in areas such as communication and language, professionalism, cultural awareness and development of clinical and organisational workplace competence (o).

Interventions should not be built purely on deficiencies in medical knowledge and communication[22,60,70] (CS11), but should include the professional role[90] and survival skills to enable future difficulties to be managed succesfully.[9,60,79] Organisations often focus on clinical competence and ignore crucial learning needs.

Contextual factors of training: external to programme implementation

Ongoing support (training, peer and supervisory)

Ongoing support is central to IMGs' transition (c)[2,12,16,25,26,28,30,32,34–38,40,41,44,47,50,53,55,56,59,62,64,67,68,70–72,74–78,81,83–87,90,91,101] (CS7, 9, 11), helping them to manage stress (m) and adjust in a healthy manner.[104] High levels of support at an early stage[26,40] would be most beneficial as they will help identify any initial problems and prevent escalation (c).[22] Monitoring of progress after an induction programme[22,58] will ensure transfer of learning (m) and fitness to practice (o)[16,87] (see Appendix S4).

Implementing a buddying or mentor scheme is an effective way to provide ongoing support, enhancing the efficiency of an initial programme[42,52,67,69,85,87,104] without being costly. The needs of the individual will determine whether they will benefit from a host-country buddy[52] (CS2, 3) or an IMG buddy[53,90] (CS9). Both have advantages and disadvantages, offering different types of support. Having a personal buddy who can provide information when necessary (c) will reduce stress and anxiety and support cultural health capital (m).[37,38,103] An increase in self-efficacy (m) is likely to result from this support[26,37,87] (CS2), this confidence ultimately being applied in the learning environment (o).[67] Retention is also more likely, with the ability to adapt to and master new skills (o).[47,87]

Supervisors are key to providing ongoing support and regular feedback (c).[2,5,9,23,27,32,34,37,42,44,47,48,54,58,59,64,65,67,73,74,76,78,83,87,89,101] Supervisors should be involved with both the implementation of the intervention and individual needs assessment,[47] aiding transformative learning (m) and providing a platform for continued professional development (o)[58,67,85] (CS9). The quality of supervision is

important, as IMGs often require more support than host-country graduates,[2,32,54,76] which can be time consuming[27,67] (CS1-3).

Peer support in practice is also essential to ensure the necessary support is available.[25,26,33,35,42,47,48,53,54,56,67,83,84,97] It is noted that there is often a lack of support and cultural awareness amongst colleagues[55,64,78,79] (CS6, 14), which may lead to a risk of stereotyping, prejudice and discrimination (c)[34,50,52,96] (CS14). Where there are perceptions of hostility, this can hinder acquiring social capital and lead to stress, anxiety, feelings of exclusion and poor cultural health capital (m).[34,52,55] This impact upon resilience in overcoming difficulties[55,79] will hinder both performance and retention of knowledge (o).[52] For example, if there is no support from supervisors or peers, IMGs may feel unable to apply the skills they learned within the training, such as communicating with colleagues, so will not ask questions if they are unsure in practice (o)[52] (see Appendix S5).

Colleagues must understand both equality and diversity and feel able to give feedback to IMGs without the fear of being seen as discriminating. Where colleagues illustrate empathy and support,[82] being appreciative of past experiences (c), social capital is much more likely to increase, impacting intercultural communications and cultural health capital (m).[37,38,55,103] This support is also likely to increase feelings of acceptance, empowerment and both personal and professional self-efficacy (m)[37,55,67,77,81,87] (CS4). Transfer of learning is more likely to take place (o).[34,55]

Supervised practice

Opportunities to perform the learned skills in practice, with feedback (c), will both reinforce learning and aid in behaviour change (transformative learning) (m).[59,76,79] All team members need to be involved in supporting IMGs if they are to transfer what has been learned in the intervention and ultimately be prepared for practice (o).

Support network (including social integration)

Support networks should consist of IMGs and host-country graduates (c) to ensure that both bridging and bonding social capital occurs (m)[12,97] (CS7, 10). Silo social development hinders the ability to communicate with colleagues (o).[46,55] IMGs will benefit from learning through social interactions with all groups (c),[12,25] which will increase self-efficacy and resolutions of personal conflicts and lead to expressions of feelings (m).[78] However, where there are feelings of isolation and hostility from colleagues (c), there can be a dependence on those from the same culture (m) (CS6). A well-resourced work environment is needed (c).[12,26] This helps IMGs identify and connect with their network and has an impact upon transformative learning, particularly negotiation and awareness of differences (m).[12,49,60,67,78] This will in turn lead to greater levels of professional development (o).[12,78,89] Both IMGs and host-country graduates will benefit from bridging social capital (m), creating access to new resources[12,60] that will enable more positive behaviours within the workplace (both work and interaction adjustment) and increase retention (o).[25,40]

Individual contextual factors

Capacity to change

Commitment to change is necessary,[57] IMGs having to participate in and understand the need for training (c)[26,34,38,39,42,45,47,49,56,61,66,67,72,75,81,83,85,87,96,104] (CS1-4, 6, 12) if transformative learning is to take place (m). If IMGs are not accepting of the new culture (c),[52] bridging of differences between the two cultures (m)[55] and overall work adjustment (o) will not take place.

Holding an unrealistic self-image will also have an impact on this capacity to change (c)[12,26,45,46,58,66,70,76,78,79,82,86,97] (CS2, 12). This lack of self-awareness is likely to result in reduced motivation to learn (m),[48,62,63,71] for example wanting to complete the programme in the shortest possible time,[34] and resistance to feedback (m).[43] Many IMGs focus on acquiring medical skills and knowledge and so fail to see the need for other training,[60,62] which has an impact on their professional development (o).[51,85]

Incentives and expectations

Incentives for IMGs to participate in a programme (c) will have an impact upon motivation to learn (m) and transfer into practice (o)[12,24,30,35,36,39,41,44,48,54,55,58,60,65,67,69,72,79,83,85,87,91] (CS2-4, 7, 11). An individual motivated by the outcome of exams (c) may focus heavily on this[32,47,57,89,102] (CS9) and be less motivated to improve practice (m).[46,67] They may learn within the assessment context but not necessarily transfer this to practice (o). If IMGs participate when attendance is voluntary (CS3, 5, 6, 14) or there is a fee

requirement (c)[47] (CS11), their motivation to learn is likely to be high (m), whereas mandatory attendance or not requiring a fee (c) (CS1-3, 12) may produce a less motivated group (m). However, if there is a lack of insight into the new ways of practising or if IMGs do not have the self-awareness to assess their own needs, individuals will not participate voluntarily (c) (CS2) and transformative learning will not occur (m). Without incentives, individuals may be less motivated to learn (m) and more susceptible to drop out (o).[67] As discussed at the organisational level, where high commitment and support is demonstrated by the organisation, the incentive to learn is also likely to increase (m).[32,68,93]

IMGs often make real sacrifices to take up job opportunities in another country, either leaving family behind or uprooting them (CS1-3, 6, 14); therefore, they are likely to arrive highly motivated. However, this motivation may not last if IMGs arrive with unrealistic expectations and goals[54] with regard to quality of life, work experiences and their future employment opportunities (c).[48,89] IMGs must arrive aware of cultural and organisational expectations[42,44–46,67,68,72,96] (CS1-4, 6, 9, 10, 14), otherwise they are likely to face culture shocks that will hinder the acculturation process (m)[52] and overall work adjustment (particularly performance and retention) (o). Training and support programmes can therefore aid in explaining the expectations of both the organisation and the culture, and in developing realistic career goals (c)[56,89] and highlighting any potential barriers to practice (m).[48] IMGs may experience changes in self-esteem, related to these unrealistic aspirations and the discrepancy with achievement (m),[80] which will affect their professional development within the organisation (o).

Role identity

Unrealistic expectations can also be linked to role identity[26,38,45,48,64,65,67,71,72,74,76,78,86,87,101] (CS2, 6); for example, if IMGs arrive and have to take up posts that are a lower grade than expected or a different specialty[78]. The job role in comparison to their previous role may be lower in status and power,[34,42,54,96] perhaps resulting in personal, cultural and professional loss of status and identity (c).[41] Taking up the role of learner[42,54] may lead to perceptions that they are unable to use their current skills,[2,34] must deskill or 'unlearn' their old ways and conform to practice,[59] reducing self-efficacy (m).[42] IMGs have reported feeling unappreciated, targets of racism and being seen as a 'group'[67] rather than individuals (c), further hindering self-efficacy (c). IMGs have also reported that their qualifications are not recognised by their peers or employer (c).[72,78] If this is the case, motivation to learn is likely to be low and resistance high (m).[96] IMGs must be supported to maintain a positive self-image[67] and seek to establish themselves in their new social and learning environments (c), which are likely to be different to what they are used to. Combining both old and new skills[34] will reframe their professional identity and enable them to modify practice (m) and take control, leading to professional growth and cultural adjustment (o).[41,96]

If IMGs feel they need to 'prove' themselves (c)[42,58,63] (CS2), their levels of self-esteem and self-worth may be affected (m).[60,72] The feeling of not belonging, as well as not wanting to appear incompetent or weak by admitting difficulties (c),[58,94] may lead to increased anxiety[38] and communication barriers (m), which will hinder interactions with colleagues (o).[59]

Preparedness for practice

IMGs will have varying levels of clinical knowledge and experience (including learning styles)[12,16,23,24,28,29,31,41,45,48,52,54,56,58,59,61,64,65,67,68,70–72,76–79,83,89] (CS1-4, 7, 11). A lack of clinical knowledge and competence[32,46] is likely to hinder interventions for IMGs as their focus will be on lack of knowledge (c), rather than the learning outcomes of the intervention (m)[59] (CS2, 3). Educators will expect a certain level of competence and therefore will incorporate this into the content.[33] Differences in previous practice must also be acknowledged (c), an initial reluctance to question seniors or share views during ward discussions perhaps hindering transformative learning (m) and overall practice (o).[34]

Individual differences

Individual differences are likely to play a role in transition[5,12,26,34,40,42,47,49,54,62,70,75,83,84,96,99,104] (CS1-4, 6, 12). The acculturative process is mediated by individual factors such as age, gender, ethnicity, culture, personality, etc..[26,27,37,59,102,105] For example, female IMGs, who often have differing needs to men, may need different support (c). 'Home' gender roles and gender role expectations may be in conflict with those in the new culture (m)[105]. However, women have been reported to experience fewer feelings of isolation and higher levels of engagement (m).[37] Transition is likely to be influ-

enced by the personality of the individual and how resilient they are (c), culture shock being experienced by some individuals but not others (m).[26] It is essential to be aware that culture shock has been linked to poor mental health (o).[89] Individual differences (c) may therefore have an impact on acculturation (m) and create a barrier to practice (o).[48] Individual differences may also limit the emotional support offered by educators because of a fear of violating gender or cultural boundaries.[79] The differences between those from international and European countries must also be recognised (CS1-3); for example, attitudes to mistakes and feedback (m).[99]

There may well be differences in individual circumstances that have an impact on adjustment[41,52,59,71,75,76,89] (CS1-4); for example, the nature of migration, barriers faced in gaining employment and length of time living in the host country (c).[101] The process of migration itself may be stressful (m), both practical issues and lack of a social network impacting on this (c).[67,80] For example, if the individual has a spouse that has moved with him or her, or family and friends already living in the host country[101] (CS2, 6), he or she may be able to adjust more quickly (o). Acculturation can also be hindered by family issues, such as spouses or children finding it difficult to adjust.[60]

Perceived barriers

IMGs may feel that the system is unfair, particularly where barriers make entering the system and career progression difficult.[67,68,78,89] A programme for international graduates may therefore be seen as another hurdle that they have to clear (c),[59] perhaps decreasing motivation to learn (m). Being told that extra training is needed can have an impact on self-esteem (m)[55] and ultimately work adjustment (o). Barriers may also be perceived following training. For example, a sense of being unnecessarily questioned (c) will act as a threat to the sense of self (m).[96]

DISCUSSION

This synthesis has investigated interventions designed to aid the transition of IMGs to health care organisations, specifically looking at contextual factors that will mediate mechanisms that are likely to lead to a successful transition (Fig. 2). Successful interventions seem to be those that not only offer a developed programme, targeting individual needs of the IMGs within a supportive learning environment, but offer ongoing support from both peers and supervisors during and following implementation. These factors are key in prompting IMGs to engage in transformative learning, increase their self-efficacy and cultural health capital, and reduce feelings of stress and anxiety. Where cultural awareness and support of the organisation are evident, interventions are likely to be more successful, with increased engagement, motivation and commitment from IMGs. Interventions will be most effective for those individuals who have the capacity to change and maintain their role identity; organisations have to understand that IMGs will be making their transition with differing levels of preparedness and individual differences. Organisations must aid IMGs with their loss of natural support networks, feelings of isolation and pressure to take on a new culture.[60]

Findings were organised into three contextual levels, individual, training and organisational, thus developing the initial programme theory. The findings were presented in an applicable manner, focusing on context as the synthesis intended to provide guidance for those implementing programmes for IMGs. This is primarily important for educators currently implementing or developing their own interventions. At a regional level, policy makers can use the findings to develop guidelines that health care organisations can use at a local level. Programmes are currently being implemented within some organisations, but if the necessary contextual factors are not embedded, the necessary mechanisms may not be triggered, so transitional outcomes (in terms of adjustment) may be hindered. It should be the responsibility of both local and regional levels to ensure these issues are addressed.

Providing a variety of safety nets, such as induction, buddying and enhanced supervision, is crucial for successful transition, supporting recommendations from earlier research.[7] There are more issues to address than merely lack of skills. A smooth transition takes about 1 year[59] and resources are needed once IMGs begin.[35] Stress is likely to be high for this group of doctors facing challenges both inside and outside of work. Dysfunctional adjustment may not only lead to poor job performance, but also result in IMGs resigning,[13] which will have an impact on organisations.

As the 'cogs' illustrate in Figure 2, the most efficient transition process will occur if all levels are operating effectively. Although adjustment will take place at the individual level, inputs at the organisational

and training levels are crucial (see Appendix S4 and Appendix S5 for examples). The complexity of issues at all levels must be understood in order to ensure transfer of learning into practice.

Although programme content and delivery are important, an organisational culture that creates a social support network and a feeling of being welcomed and accepted stands out as having the biggest impact on IMGs' transition.[106] Individual organisations should be encouraged to develop and pilot interventions, taking into account the recommendations given in Table 2.

Strengths and limitations

The realist approach is emerging as a popular choice of methodology for understanding intervention effects in context. It is an exciting, iterative approach, which involves the negotiation between stakeholders and researchers, adding more depth than the traditional systematic approach. As a result, a vast number of context-mechanism-outcome patterns were drawn from the findings in order to build and refine the developed programme theory. This synthesis has begun to extend the knowledge base in the area of IMG transition, filling the gap that has previously been noted.[8] The detailed exploration has gone beyond the findings from a regular systematic review,[8] providing much needed theoretical explanations as to how interventions achieve their effects, and not just drawing conclusions from empirical generalisations. This synthesis does not offer particular lessons learned from best practice or a recommendation of the 'best' interventions for IMGs, but instead offers a tailored and transferable programme theory through a process of theory building. Knowing how interventions for IMGs work may prove more valuable than single recommendations in ensuring success. All of the interventions vary in terms of what they offer the IMG transition process; therefore in synthesising the data, the researchers were able to see what elements are crucial to successful outcomes and make recommendations for best practice.

Table 2 Recommendations for implementing interventions for IMGs

An individual needs assessment is crucial prior to induction, taking into account individual differences and context of the health care organisation.
Information concerning work, cultural and general issues should be sent to IMGs at the earliest opportunity.
A rigorous and mandatory induction should be provided as early as possible before IMGs begin practice; content should include communication skills, cultural awareness, and practical and ethical guidelines, with follow-up sessions throughout the year ensuring reflective practice. The induction must be flexible to accommodate the identified needs.
Those who are not in training posts should be given the same induction and level of support.
Supervisors should be made aware of individual needs and give ongoing feedback to IMGs.
Differing learning styles and cultural experiences must be taken into consideration.
Experiential learning opportunities are needed to ensure new practices are adopted and transferred into practice.
A buddy should be assigned upon arrival to provide ongoing support.
Cultural awareness within the organisation must be evident.
A robust HR process needs to be in place to ensure IMGs entering the organisation are identified.

It further highlights the vast differences in the ways interventions are being developed both within and between different countries. Therefore it is suggested that a standardised set of guidelines is developed within each country, using recommendations made from this research, to ensure effective development and implementation of interventions.

A limitation of this synthesis was the lack of objective outcome measures within the literature. The majority of papers that reported outcomes were reliant on satisfaction surveys or self-assessments, which are known to be unreliable and problematic,[107] or were purely descriptive. Small sample sizes were also common. This highlights a weakness in the current literature on IMG transition, also noted in a recent literature review.[8] Therefore there was a lack of complete rigour in the conclusions drawn, the researchers being unable to test all aspects of the programme theory in detail. However, when outcomes were lacking, they were inferred. The use of secondary searches also helped to refine theory where lacking. Where outcomes were explored in a rigorous manner, studies often lacked the rich description needed to explore the theory in detail. A realist evaluation of primary data is currently being conducted to aid in further refinement and development of the proposed programme theory.

An overlap between categories, particularly mechanisms and outcomes, arose on a number of occa-

sions, illustrating the subjective nature of the realist approach. However, these were discussed extensively and realist experts consulted when facing difficulties.

Case studies were largely limited to the UK as this was the context of the wider research. They did, however, highlight that the UK is lacking the ongoing support that other countries seem to offer IMGs. Because ongoing support is a core theme from the findings, this is something that needs addressing. Although the theory was tested in a UK context, there is international relevance, in the same way that we have benefitted from international experiences in conducting the work.

As discussed previously, it was decided that graduates from different health professions would be included, despite the focus of the synthesis being on medical graduates. Future research may therefore wish to look at the transition of other professions separately. There could, however, be an opportunity to develop interventions within organisations for all international health professionals. As this synthesis shows, the transitional needs of doctors and nurses are relatively similar and may aid in acculturation.

What still remains unclear from the findings is how to target IMGs who start outside of normal contractual dates, interventions largely being implemented yearly. The suggested ongoing support, such as buddying, online resources and information packs prior to arrival may help to overcome this issue, but further exploration is needed.

CONCLUSIONS

Designing interventions for IMGs is a complex task;[108] therefore, this synthesis describes the theory and processes needed to support IMGs to make a successful transition to their host country. The findings illustrate why interventions work (or not) and in what ways, thereby enabling those implementing interventions to make more informed choices. Systematic reviews rarely look at the underlying theories of interventions or explain the context, mechanisms and outcomes that will aid in future implementation.[18] Contextual factors at three levels, organisational, training and individual, have been proposed, and the particular importance of their interactions highlighted. Ongoing support and cultural awareness at both the organisational and training levels are crucial, whilst taking into consideration individual factors. Organisations should not expect a quick or easy transition, or ignore potential difficulties at any of the proposed levels.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Search terms.

Appendix S2. Table of inclusion and exclusion criteria.

Appendix S3. Scale for assessing relevance and rigour of papers.

Appendix S4. Example of CMOc.
Use of theory to explain why Gerrish & Griffith (2004) reported successful intervention outcomes

Appendix S5. Example of CMOc.
Use of theory to explain why one individual from case study reported transition struggle.

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